Maternal and Child Health Services
Title V Block Grant

State Narrative for Northern Mariana Islands

Application for 2013
Annual Report for 2011

Document Generation Date: Monday, September 24, 2012

Table of Contents

I. General Requirements

A. Letter of Transmittal

The Letter of Transmittal is to be provided as an attachment to this section.
An attachment is included in this section. IA - Letter of Transmittal

B. Face Sheet

The Face Sheet (Form SF424) is submitted when it is submitted electronically in HRSA EHB. No hard copy is sent.

C. Assurances and Certifications

Signed copies of Assurances and Certifications along with the Orgranizational Chart and the Maternal and Child Health grant application are on file at the Division of Public Health. All Division staff have knowledge of this information and have access to the files. MCH Block Grant narrative and 2010 Needs Assessment Report is also available to the public.

/2013/ There are no changes to this section. Once the Division website is up and running we will have a copies of assurances and certifications on the website.///2013//

D. Table of Contents

This report follows the outline of the Table of Contents provided in the "GUIDANCE AND FORMS FOR THE TITLE V APPLICATION/ANNUAL REPORT," OMB NO: 0915-0172; published January 2012; expires January 31, 2015.

E. Public Input

MCH Program works with its internal and external partners to solicit public input. As will be stated in the following narrative, MCH Program staff serves as members of committees/councils/boards of agency partners that work together to improve outcomes for MCH population groups. These include the Head Start Health Services Advisory Committee, Public School System's Early Intervention Services Program Interagency Coordinating Council, the Governor's Council on Developmental Disabilities, Connecting Families, Inc., Non-Communicable Diseases committee, Early Childhood Comprehensive System Partners, etc. We worked with these communities to conduct the Title V 2010 needs assessment by getting input from the target population they serve

We provide the community with information such as health status indicators, national and state performance and outcome measures, and survey results through print media. Contact numbers and email address are included to encourage input. We also go to villages to meet with leaders such as parish councils. The Department is working to implement its own website but one strategy for the MCH Program is to put out information on partners website such as WIC Program.

We also conduct focus groups, talk story session, interviews with key informants to assist us identify priority needs and also assess our capacity and identify opportunities to work with to expand our capacity to address priority needs. MCH also participates in other partners work to identify priorities. Lastly, we went out into the community during Walk-on-Wednesdays, Marianas March Against Cancer, Sabalu Market, Wise Women Village Project to talk to mothers, pregnant women, parents on ranking priorities.

CNMI state point of contact for grants is the Office of Management and Budget -- we do provide the HRSA's Title V web-site address to various agencies.

//2012// The opportunity for public input into the Title V MCH Block Grant application is an ongoing process utilizing a variety of activities. The application is readily available for review by the public thus in compliance with the Open Government Act. We have direct phone lines to the program and email address of program manager is published in resource directories. MCH program staff informally receives input from partners and community members via email or from face to face or telephone conversations throughout the year. At the same time we provide our partners with information we receive during our outreach work about their respective programs. We continue to seek new partners such as the MCH Committee formed by health care providers and the Commonwealth Diabetes Association. We continue to conduct presentations during meetings such as the Head Start Community Partners or the Public School System Interagency Coordinating Council. In addition we actively participate in other agency's needs assessment such as Head Start Program. We continue to participate in family surveys, focus groups, trainings, etc. Finally, we post information on our partners' websites to solicit input from the community. Please note that with the reduction in work hours from 80 to 64 MCH and other programs have increased our presence in the events thus our continual interaction with the community.//2012//

/2013/ Public input continues to be solicited through key parent and family support groups who are affiliated with MCH program. Input is also solicited during the normal course of business from agency partners at meetings held across the state throughout the year. For example, the MCH program works in partnership with other programs within the Division of Public Health that has childhood obesity as a priority as well as with other external partners such as Head Start Program. Multiple presentations were conducted about the priorities for events such as: 1) Nurses' Week; 2) Head Start Community Partners Event; and 3) Commonwealth Healthcare Corporation's board members. We have also been inviting one or two of our partners to discuss initiatives or activities that during our presentations. Due to the continued reduction in work hours we participate in events that provide the venue to meet with community members/leaders in areas addressing the state priorities. For example, we participated in the Let's Move event with a focus on nutrition and physical activity. One input that we have incorporated is the equipment loaner program to assist pregnant women with hypertension and high glucose/diabetes monitor their levels. In addition one of the recommended activities from the adolescent focus group was to provide more venues for them to get/learn information and so MCH funds air time for the Teen Talk Live show//2013//

II. Needs Assessment

In application year 2013, Section IIC will be used to provide updates to the Needs Assessment if any updates occurred.

C. Needs Assessment Summary

/2013/ Since the last needs assessment, the biggest factors impacting the needs of the maternal and child health target population in the CNMI are related to economics and changing demographics. Data from the 2010 U.S. Census show a decrease in total population (we are waiting for the official 2010 census report to see the demographic change in all racial and ethnic groups in the CNMI). In addition, since the economic downturn began, including the reduction of work hours both in the government and private sectors, more families are turning to state programs for assistance. This is evident by headlines such as 106 children on Head Start wait list, (again the official release of the 2010 Census will provide us with data on number of children living below the poverty level). These factors are indicators that more will need services and support from Title V and there will be a need for more linguistically and culturally competent programs/services.

It has been about 3 years that the Children's Clinic has full staffing as far as providers. The 2010 Needs Assessment was presented to providers at the Children's Clinic. The state priorities for infants and children were discussed and the following recommendations were made:

- ***Remove two state performance measures for children on developmental screening and BMI. Please note that we will be still be working on activities including with our partners in this two areas.***
- ***Add a state performance measure on fluoride varnish application.***

We have presented data at some of our partners meeting, including stakeholders to assist us in our public health efforts to address disparities. Some outcomes of these meetings include: bringing in the component of cultural competency in our services/activities; Asthma is one of the topics to be presented at the upcoming Head Start Program in-service for teachers; the federal takeover of our immigration has also delayed families from receiving services from state programs as they need their CWs to prove status. Although we do not have the data, as partners we agree that we see our target population needing more support as they struggle with financial challenges.//2013//

III. State Overview

A. Overview

The Commonwealth of the Northern Mariana Islands (CNMI), an archipelago of 14 volcanic islands, is approximately 3,700 miles west of Hawaii, 1,300 miles from Japan and 2,900 miles east of the Philippines. (See Map) The population of CNMI lives primarily on three islands, the major island being Saipan (12.5 miles long by 5.5 miles wide), followed by Tinian and Rota. CNMI became a U.S. Commonwealth in 1975 and its residents (excluding foreign contract workers) are U.S. citizens. The 2000 U.S. Census reported the total population of the CNMI at 69,221 residents with Chamorros and Carolinians (indigenous population) comprising 34% of the total population with approximately 90% living in Saipan. The remaining 66% of the population is comprised of guest workers from the Philippines, China, and other Asian countries; business owners from Japan and Korea; other Pacific Islanders; and Caucasians.

Per the 2005 Household, Income, and Expenditures Survey (HIES), the estimated total population in the CNMI in October 2005 was 65,927. The estimated total population for the island of Saipan was 60,608, Tinian was 2,829, and Rota was 2,490. The estimated median age for the entire CNMI population was 29.2 years of age. Persons in age groups between 20 to 44 years of age made up a relatively larger proportion (48%) of the CNMI's total population than those below age 20 (32%) and those above 44 age groups (20%). This is primarily because of the large number of migrant workers in the CNMI who fall into ages 20 to 44. Total females (53%) outnumbered total males (47%) in the CNMI's total population. The sex ratio (male/female) was 87 males to every 100 females in the Commonwealth in 2005. The largest single ethnic group in the CNMI was Filipino at about 30% of the estimated total CNMI population in 2005, followed by Chamorro (23%) and Chinese (16%). The Carolinians were about 5% of the total population. Asians made up more than half (53%) of the CNMI's total population, Pacific Islanders about 37%, and Caucasian less than 2%. Multiple ethnic persons made up about 8% of the Commonwealth's total population. About 92% (or about 35,400) of the CNMI labor force was employed in 2005. About 8% (or about 3,200) of the CNMI's total labor force population was unemployed in 2005. The median household income in the CNMI in 2004 was $17,138.

The Division of Public Health has expanded its effort to improve community access to primary and preventive health care. This is evident with our satellite clinic in the southern village in Saipan and the school-based clinic located at one of the public high school. Furthermore, Medicaid participants can access health and dental care at 4 private clinics. Some of the Division's initiatives include:

- To lessen health disparities by providing accessible primary care, enhancing disease prevention activities and intensifying public health awareness at the community level.
- To provide sustainable school-based clinics.
- To establish a comprehensive approach to health problems rather than a vertical approach such as more multi-sectored that would include major stakeholders.
- To "delink" structurally and programmatically from the Hospital Division in such areas as data and financial system.
- To develop a data infrastructure unique to the needs of all the programs in the Division.
- To decrease the burden of diabetes such as the high incidence of end stage renal disease associated with diabetes, lower extremity amputations and blindness by detection, management, and education of the community.
- To reestablish environmental health as an integral component in the health care model.
- To build up local manpower capacity for sustainability.

The Institute of Medicine (IOM) has articulated the need to address major health threats and concerns from a multi-level perspective, building partnerships across health systems, communities, academia, business, and the media, in order to effectively improve the health of the population. The MCH Program has been instrumental in forging strong partnerships to enhance disease prevention and public awareness activities. This includes our work with the school system in oral health, nutrition, and physical activity. With oral health we provide fluoride varnish

application at the WIC and Immunization Clinics; oral mouth examinations and fluoride varnish and sealant application on-site at the Head Start Center; and conduct presentations during health symposiums and parent teacher conferences. In addition, we conduct media campaigns and home visits with our partners. Please note that public service announcements such as dates and time of specialty clinics are provided free of charge from the media. The public health nutritionist is visible at all the schools to conduct nutrition and fitness activities. In fact one of the most requested speakers for the elementary school level is the nutritionist. In our work with the community it is recommended to implement activities after working hours or weekends and to go out to the villages. MCH and all the programs participate in community events and also coordinate events at the community level. For example, we implemented our dance sessions to promote physical fitness activity with the Wise Women Village Project in the evenings from 6-8 pm around the villages including Saturdays. There are around 100 women participating in the dance sessions. We hear stories from women that have lost weight, have increased their fitness activity level, have stopped smoking, and have been eating healthier. During community events like the Flame Tree Festival, the women performed a dance number at the event.
We continue to provide preventive services at our school-based clinic since 2004. The clinic is a joint effort between the Division of Public Health and the Public School System to provide preventive services to adolescents in the school environment. Services include health promotion and education, substance abuse and nutrition counseling, and referrals. MCH Program assists with enabling and population-based activities that focuses on working with the students to promote being physically and mentally healthy. We collaborate with the Public School System in our outreach activities to provide adolescents with information and tools in decision making skills and self esteem. Through the Title X Program, a sliding fee-for-service scale is based on the adolescent's own income and insurance status therefore allowing them to qualify for 100% cost coverage. We are currently working with another public high school that has a full-time nursing staff and a health center.

The program's efforts to work with stakeholders is evident with membership in the PSS Interagency Coordinating Council, Connecting Families, Inc., Developmental Disabilities Council, Head Start Health Advisory Committee, Commonwealth Cancer Association, etc. In conducting the 2010 Needs Assessment we have worked with these stakeholders to identify priority needs for their target population. We have also coordinated and consolidated awareness events with our partners. We also work with ethnic groups to assist us with our materials and translations/interpretations. Some of our partners also volunteers for activities such as Reach Out and Read and manning of our exhibits/informational tables. We have established relationships from our stakeholders thus enabling public health programs to so we do get support and corporation when we solicit.

In our efforts to improve our quality of data the Division of Public Health continues to create and implement standalone databases. The system that the hospital uses is called the Resource and Patient Management System (RPMS) and is MUMPS based. RPMS is an integrated solution for the management of clinical, business practice and administrative information in healthcare facilities of various sizes. RPMS was developed by the Indian Health Service and serves as the basis for many related programs, including the Department of Veterans Affairs' VistA system. Since its implementation in 1992 there have been minimal staff training and upgrades made to the system due to lack of state funds. The hospital information technology staff has been keeping abreast of new developments to RPMS through a consultant from Indian Health Services in New Mexico. The staff from CHC received minimal training on some modules for this system. With funding from the SSDI grant, two staff from the Health and Vital Statistics Office has attended Fileman (a report querying module) on the RPMS system. Currently, coding for RPMS is not done in real-time and therefore there is often a six month or longer lag in data becoming available in the system. Because of this, the programs at the Division of Public Health have begun to develop standalone databases or registries to collect more accurate data on our population. In addition, we work to link it with birth certificate database. It has become even more critical to ensure that data can be linked between the systems so that complex data queries can be run. Some of our system includes the EHDI surveillance and tracking system, newborn metabolic

screening database, WebIZ Registry, and we are working with a contractor for the birth defects registry. MCH Program was instrumental in reviewing the information that is on the revised 2003 birth certificate standard form.

MCH Program's work with decreasing the burden of diabetes is focused on gestational diabetes milletus (GDM). We contracted the services of a consultant to assist with the education of GDM to clinical nursing staff including case management; education and counseling is also provided to our pregnant women with GDM. We have reinstated the glucometer loaner service and the nutritionist sees the women the same day as their prenatal care visit. We have supported The Club Hinemelo'ta which is an exercise program for larger women who have diabetes or pre-diabetes; are overweight; and have high blood pressure. We worked with them to implement the exercise program on the islands of Tinian and Rota. MCH also supported the training for the facilitators of the program.

The need to build and improve our current local health care manpower for sustainability of our public health programs is critical to improving delivery of services to our community. This is also more imperative because on November 28, 2009 the federalization of our immigration went into effect. This means that by 2013 all nonresident workers have to go back to their home country. Our effort to build our local manpower goes in line with the strategic plan for future health initiatives stated in the Institute of Medicine (IOM) report. One of the four recommended approaches includes promoting the education and training of the health care workforce (IOM, 1998). We work with health professional education programs and universities to provide the training for this initiative. This includes the MCH Certificate Program from UH JABSOM; University of California Los Angeles Medical Center Women's Health Care Nurse Practitioner Program; University of Texas, Southwestern Medical Program; and the Northern Marianas College (NMC). Through the NMC AHEC program NCLEX review classes are held every year. We are also working with Southern High School on the Nursing Assistant Program. Then there is our collaboration with WHO and SPC to provide various training on developing health education materials, conducting oral health outreach activities, STD counseling, etc. We continue to bring organizations such as Colorado Hands and Voices and Center for Breastfeeding to conduct training on-island. We have staff that has received training or continuing education units online. Our challenge of meeting the health care needs of the CNMI residents within the struggling health care system have made us take into consideration the need to increase and expand our relationship with the private clinics. One of the options that has been mentioned is to expand Medicaid to the private health clinics. This option also improved our work to reduce health disparities by allowing Medicaid participants access to health care that is available at the private clinics. This solution at the same time provided us with the unique challenge of educating our community about seeking care in the private clinics since they were still coming to our clinics. (Please note that prior to February 2008, Medicaid can only be accepted at public health facilities.) This is also one reason why we include Medicaid information on our ad campaigns including information on the private clinics that are participating in the Medicaid program. A poster with this information is also put up at all the public health clinics.

The declining economic situation for the CNMI is highlighted with headlines such as NMI Nutrition Assistance Program seeks $9 million more for food stamps; Over 700 families on government's housing assistance wait list; Habitual offender a problem in the CNMI; Theft case involving youths up; 74 students remain on Head Start's wait list to meet rising food costs; CUC sets power outages; NMI April 2009 visitors arrival down 12% compared to April 2008 (for November 2009 it was 29% less than November 2008); etc. Because of our economic situation, programs at the Division of Public Health have been considerate of the financial situation of families. For example, we have programs such as Wise Women Village Project (WWVP) and the Breast and Cervical Cancer Screening that focuses on the needs of the different ethnic group in our culture taking into account their financial status. Together with our partners, the MCH Program have intensified their referrals by assisting applicants on-site, providing transportation to Medicaid or NAP, and has increased work to provide translation and translators. With assistance from ECCS Big Steps for Little Feet project and Early Hearing Detection and Intervention Program we have

been providing gas vouchers for our families.

We have also been considerate of our community's requests to bring services out to them. Again, this is evident with our partnership with WWVP. The HPV School Campaign created a model for other prevention programs by localizing educational materials and going beyond the clinic-based setting. The focus is on educating parents and high school girls on cervical cancer and HPV vaccine and at the same time provide the HPV vaccine free of charge to all the students in the CNMI.

The development of homestead lots in the CNMI is growing rapidly and is a geographic challenge in reducing health disparities. These homestead lots are both residential and farming community. Majority of the larger homestead lots are located miles away from the nearest health facility - private or governmental. There is no public transportation on the island. This has pose as a challenge for the Division in ensuring the availability and accessibility of services. For example, the Kagman Homestead area is located in the northeast side on the island of Saipan with a population of about 8,000. These are young families living in the area. There is two Head Start Schools, one elementary, middle, and high schools. The nearest health facility is located on the west side of the island which is about 7 miles away. Results from the postpartum survey shows that over 50% of women that lives in either Kagman or Koblerville either had inadequate or no prenatal care. These are two of the villages that WWVP services and Head Start Dental Program are provided. We coordinate activities with all the schools for health activities. We will again submit the Section 330 grant application to open a community health center in Kagman.

The strength of the programs at the Division of Public Health lies in the commitment and dedication of staff.

//2012// Updates on some of the Public Health initiatives:
• To lessen health disparities by providing accessible primary care, enhancing disease prevention activities and intensifying public health awareness at the community level.

As has been mention, the programs at the Division of Public Health have been mindful of the financial situation of families here in the CNMI. To ensure continuity of care we have worked with our lawmakers in the past to expand Medicaid to private health and dental clinics. We also continue to include the private sector in our trainings, community events, and provide them with educational materials/resources. Through health promotion and preventive care, we aim to eliminate causes of ill health with providing information on hand washing, health and safety conference, how to cough and sneeze per CDC's recommendation, how to take temperature, good nutrition, physical activity, etc. .We have gone back to basics in our presentations at partner's conference, parent-teachers association meetings, health symposium, day care settings presentations, camp sites, etc. (Please note that we started this for the 2011 Head Start Health Symposium in which as partners we made the theme "Importance of Health") Our work with our partners in the area of health promotion and education has empowered families to refer their children for developmental screening and/or early intervention services; provision of incentives such as gas vouchers has assisted in decreasing our follow-up rate for the newborn hearing screening program. We continue to promote public health programs via media campaigns in the local newspapers, health and sports magazines that are distributed across the islands. Other successful events include the participation in physical activity events such as walkathons to kick off any public health awareness event as well as the annual Don't be a Turkey -Walk, and our Walk on Wednesdays (WOW) with free blood pressure and glucose testing.

• To decrease the burden of diabetes such as the high incidence of end stage renal disease associated with diabetes, lower extremity amputations and blindness by detection, management, and education of the community.

On May 24, 2010 the Pacific Island Health Officers Association (PIHOA) declared a Regional State of Health Emergency due to the epidemic of non-communicable diseases (NCDs) in the

United States Affiliated Pacific Islands (USAPI), which includes the Commonwealth of Northern Mariana Islands. "These islands have some of the highest rates of non-communicable disease in the world. Diabetes, heart diseases, strokes, cancer and other NCDs are killing off Pacific peoples, placing a significant burden on their daily functionality, and threatening the national security of these island countries and territories," explained Dr. Stevenson Kuartei, PIHOA President and Minister of Health of the Republic of Palau. "Non-communicable diseases impair workers, increase
absenteeism, cause untold suffering to patients and families but also lead to increased health care costs, including off island medical referrals."

The above declaration is one example of the importance of incorporating the Life Course Theory into not just MCH Program's strategic planning but overall for the Department of Public Health. Per the resolution many NCDs are preventable and have fewer complications with early intervention; community infrastructure necessary for effective health is not adequate for the challenge of controlling NCDs. Such infrastructure includes sidewalks, dog control, night lighting, bike paths, safe beaches, car control, as well as appropriate preventive and primary services, such as nutrition, health education, community advocacy, school-based programs, and other prerequisites to healthy communities, including those prerequisites that are dependent upon other sectors, such as agriculture, fisheries, education, and trades and industry. The MCH Program Coordinator is a member of the NCD task force for the Department and also a member of the Commonwealth Diabetes Association as of November 2010.

• To build up local manpower capacity for sustainability.

The Health Resources on Health Program is a newly established under the Secretary's Office to efficiently and systematically plan and promote health workforce development for the Department. The program's sub-goal is to Improve the health of the CNMI population by investing in the Department of Public Health's health workforce through formal training and continuing education through a policy and cross-jurisdictional and sectoral collaboration approach. Some of the Program's measureable indicators include:

- Increased health workforce development capacity evidenced by an increase in the number of trained and educated public health professionals at the Department of Public Health;
- Increase in staff morale and performance, implementation of a health workforce development policy; and
- Improved access to care and positive health outcomes for the people of the CNMI.

The declining economic situation here in the CNMI can be seen with a reduction of the Department of Public Health's budget in which it is forced to operate on. The funding level has decreased from 42 million in 2001 to 22 million in 2011. The effects of the reduction in work hours from 80 hours to 64 hours are illustrated with headlines such as:

- CNMI Government shuts down (Oct 2010)
- Partial payless payday on Friday -- again (Oct 2010)
- Executive Branch to begin work reduction Oct 24 (Oct 2010)
- Gov't revenue $8 million lower than project in first 5 months (March 2011)
- Effective May 1, 2011, ongoing clients will continue to receive benefits but will see a decrease of 26.71%
- Public School System see increasing number of students from poor families (June 2011)
- Patient visits at CHC down last year (May 2011)
- Children's Clinic resumes partial operations (Feb 2011)
- 500 persons on food stamp waitlist; number seen to grow (July 2011)
- Shortages of Nurses Plagues Hospital (June 2011)

The newspapers bleed economic challenges and compounding factors are affecting our families from mortgagee bills, high utility cost as well as high fuel costs. With these concerns at the forefront and the CNMI is seeing more and more people dropping health insurance. With a reduced income and high expenses, transportation is also a factor. Families are not seeking care

early rather waiting therefore we are seeing more people being admitted rather than seen for outpatient care.//2012//

/2013/According to the 2010 U.S. Census, the total population in CNMI is 53,883 (69,221 in 2000), with approximately 90% living in Saipan. The decrease in the total population can be attributed to the declining economic situation and thus the out-migration of people, the closing of the garment industry and the implementation of federal Public Law 110-229, which removed local control over immigration. Not only has the economic downturn affected the government's ability to provide services, it has also greatly affected the population's ability to seek services. On an island where gas costs over $5.00 per gallon and minimum wage is only $5.05 per hour coupled with reduction in work hours, people are facing the very real truth of choosing to buy food for their family over such 'luxuries' as preventive healthcare or medical insurance premiums. Therefore, the community tends to seek healthcare for acute situations and severe conditions only when they cannot avoid it -- a process that often leads to poor outcomes and expensive specialty care. The population is just unable to afford the cost of medical insurance premiums, insurance co-pays, and preventive care. The situation is further illustrated with headlines such as:

- ***Tinian Clinic running on empty (9/1/2011)***
- ***Inos: Estimated deficit at 9M for FY 2011 (10/10/2011)***
- ***106 children on Head Start wait list (10/17/2011)***
- ***Aetna's rate hike is a go (12/1/2011)***
- ***Over 100 food stamp vouchers on hold (1/5/2012)***
- ***Remittance averts payless payday at CHC (2/25/2012)***
- ***17 CHC nurses resign (4/11/2012)***
- ***CNMI government again overspends on referrals and utilities (5/7/2012)***
- ***CHC's OB-GYN section running with just one doctor (7/7/2012)***
- ***CHC Pharmacy closed on weekends (7/9/2012)***

Updates on Public Health Initiatives:
-To decrease burden of Non-communicable Diseases: (It is change from diabetes to all NCDs)
The Non Communicable Disease (NCD) Bureau which was established to strengthen, unify, and enhance existing chronic disease programs resources as well as alleviate any duplication of efforts. The bureau consists of the existing prevention programs within Public Health such as Diabetes Prevention and Control Program, Breast and Cervical Cancer Screening Program, and Comprehensive Cancer Control Program. Programs transferred from CGC were Tobacco Prevention and Control and SAMSHA Programs. There are three sections under the NCD Bureau: 1) Prevention and Early Detection 2) Healthy Communities and 3) Lifestyle Promotion. The combined efforts of the programs within the NCD Bureau are aimed at providing an organized platform to that of a collective and unified voice in the delivery of resources against the leading chronic diseases affecting the CNMI population. The Bureau will be the lead in the implementation of the NCD Strategic Plan.
-Increasing access sites for primary and preventive health care services:
We are happy to announce that the CNMI's Section 330 new site grant application was approved. We are working to have the Kagman Community Health Center in operation by November of this year. We look forward to providing support to MCH services at the health center.//2013//

B. Agency Capacity

The Maternal and Child Health Program is administered under the Division of Public Health. The Program through the Southern Community Wellness Clinic and its partnership with the Hospital's Women and Children's Clinic and the Community Guidance Center provide primary and preventive health services to the community. Services include medical, dental, mental health,

substance abuse counseling, women's health, nutrition counseling, and family planning. Our collaboration makes it possible to bring health services out into the community such as the Wise Women Village Project. Our work in every health area is supplemented by enabling services including outreach, case management, educational materials, and transportation to MCH target population. Please note that we collaborate with our external partners to conduct activities in these areas. Some of our population-based activities include Medicaid eligibility assistance for children with special health care needs and the prenatal projects. The strategy is to work with the community so that we can empower the community with tools and information to make informed decisions to live healthier lifestyles. Other strategies to strengthen MCH Program's capacity to promote and protect the health of our target population are: 1) work with schools to ensure children enrolled are up to date with their immunization and on nutrition and physical fitness activities; 2) work with our partners during island-wide community events which will strongly emphasize lifestyle behavioral changes especially with health care practices, diet, and physical fitness; 3) establish a network linkage with other providers to inform them of health news, health alerts, awareness events, training, etc.; and 4) develop partnership with other agencies to ensure continuity of care. To reiterate, the strength of our work is in our collaboration with our partners.

Preventive and primary care services for pregnant women and mothers:
These services are provided at Southern Community Wellness Clinic in San Antonio Village is located in the most southern part of the island of Saipan. Please note that all services provided at the Wellness Clinic include education and counseling in smoking, physical activity, breastfeeding, nutrition, etc. In addition, HIV/STD Prevention Program, Nutritionist, and Community Guidance Center staff come and provides services on-site. Training to clinical staff is also a collaborative work. These services are also provided at the at the Women's Clinic, Adolescent Health Center, and 5 private health clinics.

- Prenatal care is provided at the Southern Community Wellness Clinic, Women's Clinic located at the Commonwealth Health Center, and Rota and Tinian Health Center. It is also provided at the Adolescent Health Clinic. In addition It is also provided at 4 private health clinics that participate in the Medicaid Program. The first visit involves prenatal first visit intake/interview by nurse, physical exam (pap test), blood work, counseling, including HIV testing. The revisit exams include monitoring baby's growth and development and the mother's condition, and counseling and education. Staffing at the Southern Community Wellness Clinic includes a family practitioner, two women's health nurse practitioners, two nursing assistants, and six registered nurses. There are three OB/GYNs at the Women's Clinic for referrals of high risk cases such as diabetes and hypertension. Prenatal care visits are provided five days a week from 7:30 a.m. to 4:30 p.m. Increasing the percentage of adequate prenatal care visits, especially during first trimester, continues to be a focus for the Division. Another focus area is to have all mothers screened during pregnancy for the following: Hepatitis B, Syphilis, Gonorrhea, Chlamydia, Rubella, Diabetes, Hypertension, Cervical Cancer, Group B Streptococcus, and antibody screening.
- Postpartum Care: Postpartum clinic is held on Mondays, Tuesdays, and Thursdays. Women identified as high-risks pregnancies are provided an appointment to see a doctor one-week postpartum. The four weeks postpartum clinic provides family planning counseling and contraceptives.
- Breastfeeding Clinic: Newborn assessments -- make sure that lungs are clear, weight gain is appropriate, regular rhythm of the heart, condition of cord, check testicles for boys, vaginal discharge. Check mother's breast for nipple sores, engorgement, reinforce breastfeeding techniques. We send two staff to attend a breastfeeding training this year. This service is provided on Mondays, Tuesdays, Wednesdays, and Fridays.
- Family Planning: The primary focus of the Family Planning Program is to reduce the numbers of unplanned pregnancies and the prevention of teen pregnancy. Family planning training was conducted to clinic providers and staff at the Women's Clinic and as of September 2008 the Clinic is another site providing family planning services. This is in addition to the Southern Wellness and Adolescent Health Clinics. Services are provided every day for scheduled appointments and walk-ins.
- HIV/STD Prevention: The HIV/STD Resource and Treatment Center opened in 2002. The

center, located away from the Commonwealth Health Center, provides pre and post counseling, partner identification and notification, treatment, and case management. Some goals of the program include opening test sites out in the community and mass media campaigns emphasizing on behavioral change. It works closely with the school system and other community groups to conduct educational awareness activities. Training for staff, including nurses at the public and private sectors, on HIV pre and post counseling is done every two years. Testing is currently done at the Southern Wellness and Adolescent Health Clinics, and the Commonwealth Health Center.

- Breast and CervicalCancer Screening: Breast cancer and cervical cancer screening exams such as pap smears, clinical breast exams, and mammograms are provided to women over 40 years of age at no cost to women that meet the program's criteria. Eligibility assistance and transportation is provided to clients; transportation includes air fare tickets to clients form Rota and Tinian for mammograms. In addition, program staff conducts outreach presentations on early detection and prevention including risk factors. Supplemental activities include providing services at night and free mammograms for one month for all women, and expanded outreach activities with partners such as MCH during awareness months.
- Wise Women Village Project: provides women-focused services and counseling to target groups in the villages with partners.
- Women's Health: Gynecological services -- pap smears and consultations - are provided at the satellite clinics, and Rota and Tinian Health Centers. The referral clinic for complicated cases is the Women's Clinic at Commonwealth Health Center.
- Health screenings such as blood sugar, blood pressure, weight, etc. is provided daily on a walk-in basis. This is also conducted during community events.

Preventive and primary health care services for infants and children:
These services are provided at the Southern Community Wellness Clinic, Children's Clinic, and 5 private health clinics.

- Immunization: The Immunization Program provides the vaccines for children, works with the schools to ensure that all children are up to date with their vaccinations, collaborates with the private clinics to ensure availability and accessibility of service, and overall continue to work to achieve goals and objectives in the measles elimination plan for the CNMI. Immunization is provided at the public health facilities and all of the six private clinics. The basic immunization series includes Diphtheria, Pertussis and Tetanus (DTap), Polio (IPV), Mumps, Measles, and Rubella (MMR), Hepatitis B (HBV), and Hemophilus influenza type b (Hib), Pcv 7, Rotavirus, Pediarix. The staff are tracking children that are not up-to-date and making telephone calls to parents on a daily basis. For those children that have no transportation the nurse goes on home visits to give the shots. Supplemental activities are done during immunization awareness month with extended clinic hours, providing immunization during community events and providing immunization out in the villages. We work with our partners to provide awareness on the importance of age appropriate immunization such as WIC. Walk-in policy has been reinstated. One of the challenges for the Program and other programs is the migratory pattern of our population. In addition, the program is responsible for the issuance of the school health certificate upon completion of immunization. By law, all children are required to be up-to-date on their immunizations before they can enter school.
- Well Baby/Child exams are provided at the wellness clinic and Children's Clinic. The function has been transferred out to the satellite clinic; appointments are made to the Children's Clinic at the parents' request. Services provided include immunization, health education and counseling including nutrition, injury prevention, safety, assessment and monitoring for growth and development and other underlying health problems, and physical examinations. Referrals are also being done such as for dental care, hearing screening, early intervention services, specialty clinics, and home visits. The promotion of breastfeeding is actively done during these visits. Physical examinations include vision and hearing screening. Again, the referral site for complicated cases or for consultation is the Children's Clinic. There are currently three pediatricians. This clinic is held every Mondays, Tuesdays, and Thursdays.
- Newborn Hearing Screening: We have been successfully screening 98% of our babies before hospital discharge. We continue to work with the 1-3-6 model as program benchmarks.

We have been focusing our quality improvement activities to reduce our loss to follow-up numbers. We provide annual training to nursing and early intervention services program staff on all component of an early, hearing, detection, and intervention program. The EHDI surveillance system has been instrumental in identifying babies that are not screened for hearing loss and those that do not come back for the second hearing test

- WIC Program:The Special Supplemental Nutrition Program for Women, Infants, and Children - better known as the WIC Program - serves to safeguard the health of low-income women, infants, & children up to age 5 who are at nutritional risk by providing nutritious foods to supplement diets, information on healthy eating, and referrals to health care.
- Outreach Program: This consists of the home visit nurses. The two barriers to the program are first the inadequate numbers of staff to fully attend to the increase load for home visit and transportation.
- School Health Program:

1. A school health certificate is required for all children entering school for the first time in the CNMI. In order to get the school health certificate a physical examination (including hearing and vision screening) is required and they must have completed the required immunization series for that age group. Parents continue to call to schedule physical examinations in late July and August. Physical examination is also provided at the private clinics.
2. School Dental Program: This program has proven to be one of the successful collaboration between the Division and the School System (both public and private) and the parents.

- Head Start Program -- As of 2008, dental assistant go to each Head Start center to provide mouth examination, fluoride varnish and sealant application, and education. The Program purchases the supplies and Public Health provides the staffing. We have also been scheduling appointments for those children enrolled in the Medicaid Program for their restorative treatment needs. As of February 2009, 4 private dental clinics are accepting Medicaid. This information and Medicaid Program's information is included in all our media campaigns. Every year we conduct oral health presentations during the Parents Health Symposium.
- First, fifth, and sixth, including private schools -- Every school year children in first, fifth, and sixth grades in the public and private schools, including Rota and Tinian, are bussed to the Dental Clinic per an agreement with the public school system. Services provided include mouth examination in which they are assessed for caries and periodontal diseases, sealant application, and education. The children are given report cards on their dental assessments so parents can make necessary appointments for further dental treatment and procedures. The Dental Clinic provides services that include general dentistry such as sealant application, fluoride tablets, education/counseling, community outreach activities, cleaning, extraction, and fillings. With the recruitment of another dental hygienist, more awareness and education on oral health will be provided at the school level. Building up the skills of staff and replacing/upgrading the equipment continues to be a focus of the Dental Unit.
- Mental Health and Social Services: School counselors and other service providers work closely with the staff of the Community Guidance Center for provision of services at the school-based clinic. Staffing includes one psychiatrist, three mental health counselors, two social workers, one prevention manager, one program coordinator, one tobacco coordinator, one health educator, and one health educator assistant.

In addition, the early childhood comprehensive system partners are working together to ensure that children are healthy and ready to learn at school entry. We have increased our public awareness campaign on children's growth and development in collaboration with CDC's "Learn the Signs. Act Early" Campaign. We continue to be a referral source to four private health and dental clinics providing service to Medicaid participants.

Services for children with special health care needs:
The Children with Special Health Care Needs (CSHCN) Program is a component of the MCH Program. Services are set up to promote an integrated service delivery system for CSHCN from birth to twenty-one years of age and their families. We work to ensure that children not only receive specialized health care that they need but that they are up-to-date with their

immunizations and that they avail, if qualified, to the different social service programs on island. One priority of the program is to identify these children at the earliest age possible, preferably right after birth. The entry point is a referral to the Early Intervention Services (EIS) Program located at Children's Developmental Assistance Center (C*DAC). In reviewing our data the average age for referral for all children is at 29 months. There are care coordinators, special education teachers, social worker, and occupational, physical, and speech therapists on staff for the 0-3 years old. We have a community health nurse who oversees the coordination of specialty care that our children need. The Program works collaboratively and cooperatively with other agencies and departments to provide appropriate education and support services needed to meet their social, emotional, physical, and medical needs. Specialty clinics, such as Pediatric Cardiology and Shriners, are conducted twice a year, annually, or every other year. We work closely with health care providers and the Medical Referral Program to ensure that our children needing extended care go off-island. We procure contractual services such as the audiologist to provide services to our children. We continue to provide transportation, eligibility assistance, and continue with activities such as parent events, health forums, trainings, etc. We have been working with different support groups such as Deaf and Hard of Hearing, Autism, etc. to implement activities to promote and sustain these support groups.
We continue with challenges for the program that include:
• lack of qualified professionals on-island for specialized services;
• clients who do not qualify for SSI, Medicaid, etc., because of citizenship status
• lack of respite care facility for families of CSHCN -- please note that through the CNMI Developmental Disabilities Council in which the MCH Program Coordinator is a member, we did apply for a Real Choice Systems grant to provide respite care. However, funds are not enough for everyone and only one provider applied.
• Pediatricians are on a two year contract and we continue to struggle with the shortage of pediatricians. Parents/children get use to one particular provider and after two years he/she does not renew and thus a change in provider. This was one thing mentioned from the survey as far as continuity of care.

We continue to work with our college on training such as the UH LEND Program that provided training to physicians, nursing staff, and early intervention services staff (includes private clinics and Public School System Special Education Program staff) on disability that included cultural aspects, developmental screening, autism, etc. We have been focusing our collaboration with new partners to address needs of our children with special health care needs. One good example of this is last summer the USN 4th Medical Battalion with the lead of Capt. Anita Kobuszewski provided dental care services to children with special health care needs as part of their Innovative Readiness Training mission.

Preventive and primary health care services for adolescents:
Services provided at Adolescent Health Clinic, Women's Clinic, Southern Community Wellness Center, Children's Clinic, HIV/STD Resource Center, and 5 private health clinics.
The Adolescent Health Clinic is a school-based clinic located at one of our largest public high school. The clinic sees an average of 178 students per month. The overall goal of the Clinic is to make preventive health services available to teens while educating them on how to take responsibility for their own wellness. Clinic appointments are often full booked. Other Department staff continues to provide services on-site including Community Guidance Center, HIV/STD Prevention Program, Family Planning Program, etc. One full-time RN staffs the Clinic and other providers are rotated through to provide specialized services. Educational pamphlets on health issues specific to adolescents are readily available and classroom presentations are provided upon request.
The Division has managed to remove the barrier of access to service by meeting teens in their environment thus eliminating disparities. This clinic meets the students in a confidential setting where education and clinical exams are achieved on site. Onsite educational and clinical services in the high school setting allow ease of access, confidentiality, and personal counseling within an environment that is neither restrictive nor intimidating. Students are always encouraged to include

their parents or families in decision making especially on sexuality.

HPV School Campaign - During the 2007-08 academic school year, the Immunization Program and its Stakeholders: Breast & Cervical Cancer Screening Program, Commonwealth Cancer Association, Maternal and Child Health Program, Parents and schools (Public & Private) formed a community coalition to provide Human Papillomavirus Vaccine (HPV) to all girls 11 to 18years of age.
We conducted a media campaign in which it received national recognition and award to educate the general public about the extend of the cervical cancer problem in the CNMI, the availability of a vaccine to prevent cervical cancer and details of the school campaign. The goal for the program is to vaccinate all female gender within the age eligible group, to reduce the prevalence rate of cervical cancer in the CNMI. Currently 75.5% of girls enrolled in the public high schools have received all 3 doses of the vaccine.

To enhance our capacity to promote and protect the health of all mothers and childen, including CSHCH we have been building our data infrastructure through SSDI grant for newborn hearing screening, newborn hearing screening and at the present time birth defects database which are linked to birth certificate database These databases allow us to collect data according to different ethnic groups and assist us expand our work with that particular group. We have translated newborn hearing screening materials to Korean and Chinese because in reviewing our numbers they are the ethnic group that refuses the service.

//2012//The Department of Public Health locally funds all direct health care providers such as nurses, lab unit staff, physicians, mid-level providers, dental staff, and CSHCN staff. For the past 10 years, the Department's budget went from 42 million to 22 million. Thus, federal grants are the primary source of funding for the majority of public health infrastructure, services and activities. The MCH Program operates within the Division of Public Health that also oversees other federally funded programs such as HIV/STD Prevention Program and Home Visiting Program.

The MCH Program continues to focus its work to protect, promote and improve the health and well-being of women, children and adolescents, including those with special health care needs. Priority needs include improving pregnancy and birth outcomes, improving the health of children and adolescents, including those with special health care needs, assuring early identification and intervention to services, and strengthening the MCH infrastructure.

The MCH Program works collaboratively with agencies/programs that are state funded such as Division of Youth Services and Public School System.

SERVICES FOR PREGNANT WOMEN, MOTHERS, INFANTS

Currently all primary and preventive services for women and children care are provided at the Women's and Children's Clinic located at the Commonwealth Health Center. There are three mid-level providers stationed at the Women's Clinic. This has allowed for more efficient case management of high-risk pregnancies.

With the newborn metabolic database we have been working with Children's Clinic staff on follow-up for retest and also for making sure that those needing treatment receive it. Every year we work with the Oregon State Public Laboratory to compare our numbers we report on Form 6 and this year our database showed one infant that tested positive for amino acid with a note stating that a letter was sent to appropriate staff. We have been comparing our data with the Lab and this year it reported that we had 0 positive for 2010.

One of the state priorities is case management of pregnant women identified as ‘high risk'. One of the mid-level providers is currently overseeing GDM patients or diabetic patients. We are working to include women identified with other high risk factors besides diabetes.

Through a grant from CDC the Health Resources Infrastructure Initiative was implemented last year. The goal is to improve the health of the CNMI population by investing in the Department of Public Health's health workforce through formal training and continuing education through a policy and cross-jurisdictional and sectoral collaboration approach. One major activity is the High School Nursing Assistantship Program in which 11 students graduated last week. 2 graduates will be attending nursing school off-island, 6 will attend nursing school here and 3 have plans to further their education in the health field but not nursing. Furthermore, the Commonwealth Board of Nurse Examiners (Nursing Board) gave approval to administer the Certified Nurse Assistant Examination this year to the students.

We are working with ECCS and its partners to implement the Ages and Stages Questionnaire: Social Emotional screening tool.

The Home Visiting Program is designed: (1) to strengthen and improve the programs and activities carried out under the MCH Program; (2) to improve coordination of services for at risk communities; and (3) to identify and provide evidence-based home visiting programs to improve outcomes for families who reside in at risk communities

SERVICES FOR CHILDREN AND ADOLESCENTS

MCH has partnered with many state public and private agencies to implement the Early Childhood Comprehensive System (ECCS) grant. Under the leadership of MCH, ECCS has strengthened the linkages among key partners with a broad focus on early childhood policies, programs, and services. Work over the last year has strengthened links among providers of service to young children in the areas of the five critical components of the ECCS grant: access to health insurance and medical home, mental health and social-emotional development, early care and education, parent education and family support. ECCS has strengthened our work in raising awareness of children's mental health at the division level and with our partners.

Oral Health Initiatives: We implemented the fluoride varnish application and oral health education activity at the WIC and Immunization Clinics. In addition, dental assistants provide oral health education to pregnant women at the Women's Clinic. Appointments are also scheduled for sealant application at the dental clinic or as walk-in.

SERVICES FOR CYSHCN

The MCH Program through its ECCS Big Steps for Little Feet Project and its partners has increased awareness campaigns for autism. One of the weaknesses stated in our Act Early Summit plan is there is nothing being done to educate the community on autism. Awareness activities include our media campaign, giving parents a short quiz that we got from the CDC Act Early website, and train early intervention services program staff on autism. Key staff participates in training such as the Inclusive Education and Autism sponsored by Council on Developmental Disabilities and others.

The Birth Defects Database was implemented early 2010. We still have challenges with inputting correct information into the database such a prematurity as a diagnoses. We have one MCH staff that generates monthly reports and we then make sure to link families to the Early Intervention Services Program.

Early Hearing Detection and Intervention: The program work to ensure infrastructure building functions such as data collection, needs assessment, surveillance, planning and evaluation, systems and policy development, monitoring, provision of training, and technical assistance to assure quality of care.//2012//

/2013/The budget cuts, the out-migration of people combined with still unresolved issues

surrounding federal immigration policies causes impedance to securing or retaining nearly any type of medical personnel. Three has been cuts in services including staff with the transition of the Department of Public Health to the Commonwealth Healthcare Corporation . As was mentioned, federal public health grants have been the primary source of funding for services, activities, and infrastructure for programs in the Division. In line with the Division of Public Health's mission statement: "To achieve optimal health and well-being of the NMI through protection, promotion, and prevention of disease in partnership with the community", the MCH Program continues to support and enhance the provision of preventive and primary health care services.

Services for Pregnant Women, Mothers, Infants
The Women's and Children's Clinic located at Commonwealth Health Center provides comprehensive primary and preventive services for MCH target group. As of July 2012, there is only 1 OB/GYN working at the Women's Clinic in addition to 2 mid-level providers. However, there are 5 pediatricians at the Children's Clinic. The MCH Program provides enabling services such as case management, educational materials including DVDs and incentives such as gas vouchers. To assist them in their work to improve health outcomes, MCH has provided the equipment for the loaner program, sponsored the Perinatal Continuing Education Program training for the nurses as well as training on newborn hearing, oral health, and breastfeeding. The Triple Treat Classes is the outcome of our collaboration with WIC and the Hospital. We provide eligibility assistance when requested for Medicaid and assist with referrals and tracking. We look forward to working with the Kagman Community Health Center especially as one of the factors of not seeking care is the lack of transportation. The site of the FQHC is located at the northeast part on the island of Saipan in which there are around 4,000 households living there as well as a Head Start Center, a public elementary, middle, and high schools. One of our biggest challenges is newborn metabolic screening. Due to shortage of funding, it has been suspended as the Corporation has not made payments to the lab in Oregon. However, we are working on strategies with the lead of the medical director to provide the services. Please note that we want to acknowledge the work of Dr. Jeanolivia Grant to the MCH Program. She has been our champion in integrating public health into primary care setting.

Services for Children and Adolescent
Health care services for children and adolescents are provided at the Children's Clinic and Adolescent Health Clinic located at one of the public high schools. Again, MCH Program provides enabling services such as transportation, translation, referrals, incentives, and educational materials. Through ECCS and home visiting, we have also been assisting families navigate through state programs. Majority of our families seek assistance for WIC, Food Stamps, and Medicaid. One of our new partners for adolescents is the Teen Talk. Live
Infrastructure Building: training, submission of grants, KCHC

Services for Children and Youth with Special Health Care Needs
One of the biggest challenges with our special needs population is the lack of specialty care on island. They are send off-island for care which adds financial burden to the families. As of April of this year, Shriners Hospital in Honolulu now pays for the air fare costs of the child and an escort if they have to come to Honolulu for surgery. We have been in discussion with them since last July because the Medical Referral Program was not able to sent two children to Honolulu for their scheduled appointments early part of 2011. We continue to provide enabling services such as transportation, translation, educational materials, awareness campaigns, and care coordination with our partners. We are now using ASQ at the early intervention services program and we are working with daycare centers to be implemented there. Again we look forward to working with the FQHC in Kagman for to ensure provision of services for our special needs population. The Division received funding to implement telehealth which will help us improve case

management of the children in addition to having access to specialties off-island.//2013//

C. Organizational Structure

The Commonwealth of the Northern Mariana Islands (CNMI) is self-governing with locally elected governor, lieutenant governor, and legislature. In 2009, Benigno R. Fitial was re-elected Governor of the CNMI with a new lieutenant governor, Honorable Eloy Inos. Each state agency is under the supervision of the governor and is headed by a single executive. The governor appoints the heads of executive departments with the advice and consent of the Senate. Being a state agency, the Department of Public Health is headed by a Secretary of Public Health. Since 2006, the Department has been guided under the leadership of Mr. Joseph Kevin Villagomez as the Secretary of Public Health. The Secretary is the authorized representative for the Department and serves as a cabinet member. The Department comprises of three (3) Divisions: Hospital Division, Community Guidance Center and the Division of Public Health. Deputy Secretaries for Hospital and Public Health Division is also appointed with the recommendation of the Secretary of Public Health; the Community Guidance Center is under the leadership of a Director. The Medicaid Program and the Medical Referral Program are two line programs that are organizationally structured under the Department of Public Health.

The Department of Public Health is part of the Executive Branch of the CNMI government. PL 1-8, Chapter 12, SS2 give the Department the powers and duties to:

- maintain and improve health and sanitary conditions;
- minimize and control communicable disease;
- establish standards of medical and dental care and practice and to license medical and dental practitioners;
- establish and administer programs regarding vocational rehabilitation, crippled children's services, infant care, Medicaid, Medicare, mental health and related programs including substance abuse;
- establish standards for water quality; and
- administer all government-owned health care facilities.

The mission of the Department is to "Promote the health and well being of the residents of the Northern Mariana Islands by protection through sanitation, immunization, and other communicable and non-communicable disease programs; Improve the quality of life through encouraging and empowering the community to achieve its highest possible level of wellness and; Ensure the availability of efficient and quality health care and prevention services".

A Deputy Secretary that is appointed by the Governor with the recommendation of the Secretary of Public Health oversees the Division of Public Health. Mr. John Tagabuel has been appointed in the acting capacity since October 2008. Dr. Richard Brostrom, Public Health Medical Director, provides guidance to all preventive health programs. The Division of Public Health's mission is twofold:

- To improve the quality of life through empowering and encouraging the community to achieve its highest possible level of wellness;
- Ensure the availability of quality health care and prevention services.

The Division of Public Health is responsible for administering the State's Title V Maternal and Child Health Program - Prenatal and Postpartum Care, including children with special health care needs and other preventive health programs. The State System Development Intiative project (1 staff), Early Childhood Comprehensive System Project (1 staff), and Universal Newborn Hearing Screening/Early Hearing Detection and Intervention (2 staff) are under MCH Program. Other programs in the Division include:

- Diabetes Prevention and Control Program (staffing include Program Coordinator, Administrative Assistant/Tracker, Community Health Specialist)

- Breast and Cervical Cancer Screening Program (staffing include Program Coordinator, Data Management Specialist, Community Outreach Worker, and Administrative & Tracking Assistant)
- Immunization Program (staffing include Program Manager, IMM Info System Administrator, Immunization Clerk (1- Rota, 1- Saipan, 1- Tinian), VFC Coordinator, Staff Nurse, AFIX Outreach Worker, Community Outreach Worker, VPD Tracking Coordinator, Perinatal Hepatitis B Coordinator)
- Women, Infants, and Children's Program (staffing include Program Administrator, Nutritionist, Breastfeeding Services Coordinator, Financial Analyst, Financial Manager, Quality Assurance Coordinator, Vendor Management Coordinator, Administrative Assistant, Nutrition Technician (7), Information Clerk, Nutrition Assistant (2), Clinic Administrative Assistant, Office Manager, System Administrator, Clinic Manager)
- Early Hearing Detection and Intervention (staffing include Follow-Up Coordinator, Data Tracker, and contractual services of Audiologist and Computer Specialist)
- Health Promotion (all Community Outreach Workers from all the Programs)
- Family Planning Program (staffing include Program Coordinator, Nursing Assistant, Registered Nurse)
- HIV/STD Prevention Program (staffing include Program Manager, Community Health Worker, HIV Case Worker, STD Case Worker, Clinical Attendant)
- Comprehensive Cancer Control Program (staffing include Program Coordinator, Data Coordinator, Community Outreach Worker)
- Wise Women Village Project (staffing include Program Coordinator, Case Manager, Community Outreach Worker)
- Office of Epidemiology -- (Epidemiologist)

In addition, the Division administers the Bureau of Environmental Health (11 staff); Early Intervention Services Program (4 staff); Adolescent Health Clinic (1 staff); Public Health Liaison Office (1); Dental Unit (10 staff); Southern Community Wellness Clinic (10 staff) Public Health Emergency Preparedness (2 staff) and Chest Clinic (5 staff).

Other units include Health and Vital Statistics Office (3 staff); Accounting; and Administrative Support Service (4 staff). There are program mangers that oversee these different programs/units. These services are also provided at the Tinian and Rota Health Centers. A Resident Director oversees services provided in Rota and Tinian.

The Department of Finance and Accounting is responsible for the financial management of all funds, both local and federal. The Department is responsible for draw downs, submission of financial status reports, and checking/approving all funds to be used. The Governor's Office approves the expenditures of funds such as personnel, travel, purchase orders, contracts, etc.

//2012//The only change is the addition of the Home Visiting Program. The program's FTE consists of a project coordinator, data specialist, community outreach worker, family partner advocate (vacant), and a nurse (vacant).//2012//

/2013/ Public Law 16-51 dissolved the Department of Public Health and created the Commonwealth Healthcare Corporation (CHCC). CHCC is a government corporation, and while it is a part of the CNMI government, it is semiautonomous. The CHCC is now the operator of the Commonwealth's healthcare system and the primary provider of healthcare and related public health services in the CNMI. This law transferred all the functions and duties of the CNMI Department of Public Health including management of federal health related grants to the Commonwealth Healthcare Corporation, so that the CHC is the successor agency to the now defunct Department of Public Health. The Chief Executive Officer of CHCC is the authorized representative for the MCH Program. The Medical Director also provides oversight to the program also. There are two divisions under the corporation: 1)Public Health -- provides preventive and community health programs in which many are federally funded; and 2) Hospital. The following are appointed senior

leadership positions:
Mr. Juan N. Babauta, Chief Executive Officer
Ms. Roxanne Diaz, Director of Public Health Services
Dr. Daniel Lamar, Medical Director for Public Health
Please see Other MCH Capacity for bio sketches//2013//

An attachment is included in this section. IIIC - Organizational Structure

D. Other MCH Capacity

Key personnel involved in MCH activities include:
Secretary of Public Health: Mr. Joseph Kevin Villagomez, MA was appointed by Governor Benigno R. Fitial to be the Secretary of Public Health in 2006. Mr. Villagomez holds a B.S. in Psychology from Washington State University where he graduated with honors and holds a Masters of Science in Counseling Psychology form Antioch University of New England where he also graduated with honors. Mr. Villagomez established the first ever Substance Abuse Treatment Program and the Substance Abuse Prevention Program in 1993. He has been with the Department since 1992 and he was the former Secretary of Public Health from 1998-2002. He was also the primary reviewer for American Samoa's MCH grant application in 2001.

Deputy Secretary for Public Health Administration (DSPHA): Mr. John Tagabuel was appointed Acting DSPHA by Governor Benigno Fitial in 2008. He was the Chief of Bureau of Environmental Health. He has extensive trainings in food policy, food safety, and food security.

Public Health Medical Director: We are currently processing recruitment papers for Dr. Daniel Lamar with a start work date of July 5, 2011. His specialty is in Family Medicine.//2012//

OB/GYN Physician: //2012//Jeanolivia Grant, MD, graduated from Thomas Jefferson University Medical School and completed her residency at Temple University in the inner city of Philadelphia. She is currently working on a master's degree in Public Health from the University of North Texas. She provides clinical services as well as offering input and assistance to the Division of Public Health's programs such as MCH and BCSP in areas pertaining to Women's Health.//2012//

Public Health Dentist: Dr. Alberto Ventura, DMD, received his Doctorate degree in Dental Medicine (Cum Laude) from the University of the East, Manila, Philippines. He is licensed by the CNMI Medical Profession Licensing Board, and has been providing his services to the Division since 1982.

Women's Health Nurse Practitioner: Mrs. Luise Q. Noisom, RN, BSN, WHNP, is a nationally licensed Women's Health Nurse Practitioner since 2002. She has been working for the Division of Public Health since 2001; however, she has been practicing as a nurse for the Commonwealth Health Center since 1989. Mrs. Noisom received advanced education and training from a master's certificate Women's Health Care Program at the University of Texas, Southwestern Medical Program in 2000. She provides women's health services at the satellite public health clinic.

Women's Health Nurse Practitioner: Mrs. Bertha Peters Camacho is a nationally licensed Women's Health Nurse Practitioner since 2001. She has been working for the Division of Public Health since September 2001; however, she has been practicing as a nurse for the Commonwealth Health Center since September 1997. Mrs. Camacho also received her advanced education and training from a master's certificate Women's Health Care Program at the University of Texas, Southwestern Medical Program in 2000. She provides women's health services at the satellite public health clinic including the Adolescent Health Center and STD Clinic. Mrs. Camacho participated in the MCH Certificate Program from the University of Hawaii.

Public Health Program Analyst: Ms. Roxanne Diaz received her Bachelor's Degree of Science in Biology from Chaminade University, Honolulu, Hawaii. Her primary function is to monitor all federally and locally funded programs, correspond with the local academic community, explore and identify various education, training, funding, and/or technical assistance available that may be beneficial to the Department. She completed the MCH Certificate Program from the University of Hawaii in 2008.

MCH Coordinator: The MCH Coordinator is Mrs. Margarita Torres-Aldan. Mrs. Torres-Aldan holds a Master's Degree in Public Health (Health Service Administration) from the University of Hawaii and A Bachelor of Science Degree from the University of Colorado, Denver. She has experience in the field of social work, including interagency liaisons, adolescent health, and services for children with special health care needs.

Family Planning Program Manager: Arielle Buyum, MPH, CPH, received her master's degree in public health from the Rollins School of Public Health at Emory University and is also a bachelor prepared registered nurse. She currently implements the Title X family planning services grant, coordinates adult and adolescent reproductive health services, and directs the family planning/HIV integration special project.

Community Health Nurse: Ms. Dianne Francisco is the Adolescent Health Center Coordinator at the Marianas High School. She is a registered nurse who received her degree from Northern Marianas College. Ms. Francisco provides health services to the adolescent population, primarily in the field reproductive care. Her duties include family planning counseling and services and sexually transmitted disease education, prevention, and testing.

Public Health Registered Dietitian: //2012// Vacant FTE //2012//

Epidemiologist: Mr. Edward Diaz, graduated with a Masters of Public Health Degree in Epidemiology from the University of Hawaii. He joined the Division staff in May 1998. Some of his professional interests include disease intervention programs, data collection, disease reporting, and health information system, communicable and non-communicable disease surveillance and outbreak investigation. He currently is the director for the communicable disease program.

Statistician IV: //2012//Mr. Vince Castro is currently Acting Health and Vital Statistics Office Manger due to the untimely passing of Mr. Isidro Ogarto. He is also the Program Manager for the Promoting Integration of State Health Information Systems and Newborn Screening Service Systems Project (PISHIS).//2012//

State System Development Initiative Project Coordinator: Ms. TaAnn Kabua recently joined the Division of Public Health in April. She has an Associate's Degree in Liberal Arts from Leeward Community College. In collaboration with the Office of Health and Vital Statistics and other programs required to report data, she participates in the development, integration and implementation of comprehensive supporting IT infrastructure to include data sharing systems, data linkage, web-based e-government systems and the Division of Public Health Administration wide internet access.

Accountant IV: Ms. Frances Pangelinan has been with the Division for the past 15 years. She has extensive experience in banking and financial management. She currently manages all federal and local accounts.

Immunization Program Manager: //2012//Jeremy Sasamoto graduated from Washington State University. He began working for the CNMI as a Computer Specialist for the Superior/Supreme Courts of the CNMI before moving on to become the Systems Administrator for the Immunization Program at DPH until becoming the manager in May of 2010. He also manages the 317 grant, Pandemic Influenza grant, and Section 317 ARRA grant (2010-2011).//2012//

Breast and Cervical Screening Program Manager: Ms. Jocelyn Songsong has been with the Division of Public Health since August 1998, and currently manages the Breast and Cervical Screening Program. She received her associate degree in Liberal Arts at the Northern Marianas College in 1995 and has attended various professional education trainings.

Diabetes Control and Prevention Program Manager: //2012// Ms Janet Maratita is currently the manager and joined the Division last year.//2012//

HIV/STD Program Manager: John Dax Moreno is the Communicable Disease Manager for the CNMI DPH HIV/STD Resource & Treatment Center. He implements the CDC's HIV Prevention Projects in the Pacific, Comprehensive STD Prevention Project and Infertility Prevention Project, HIV/AIDS Surveillance, and HRSA's Ryan White CARE Act Part B that provides treatment and Core Services for People Living with HIV/AIDS. He has an Assosciates Degree in Nursing Science from The Northern Marianas College.

We also have contractual services of Angie Mister, AuD, that provides program oversight and audiological services for our newborn screening program and Mr. Quan Shengsong is our contractor for the EHDI surveillance system, newborn metabolic screening database and the birth defects database. Both have been instrumental in the linkage of our programs with the birth certificate database.

Administrative staff provides support in clerical, procurement of supplies, inventory control, processing of travel papers, and time and attendance. The Health and Vital Statistics Office is responsible for processing birth and death certificates in addition to data collection for the Division. Our dental assistants and dental hygienists continue with the Head Start and School Program. They expand their service to home visits and have formed partnership with other programs such as WIC to provide fluoride varnish application at their clinic.

Our staff that provides service coordination for children with special health care needs is a parent of a child with special health needs. She has a nursing background and is multi-lingual. She has been instrumental in bringing in parents to participate and facilitates parent events. We have found that parent involvement for CSHCN has increased since we have been working with the different groups. For example, there are 4 parents that have submitted their interest to join the Interagency Coordinating Council for the Early Intervention Services Program even though we have 1 year remaining for membership re-appointment. We have an active support group for our parents that have children that are deaf and hard of hearing. They have implemented every other week Sign Night, have facilitated and coordinated the annual parents retreat, and provided information on our revised written materials. There is an active Autism Society in which one of our pediatrician is a member. The MCH through the Big Steps for Little Feet Project has increased awareness of autism through print media. Parents/grandparents ranked first as the main referral source to our CSHCN or EIS Program. We also have on staff care coordinators for our early intervention services program and a social worker that assists families with needs such as transportation and access to services such as Medicaid, private dental and health clinics, WIC Program, and Nutrition Assistance Program. We work with clinical staff and health care providers for referrals and provide training and educational materials on growth and development to them. Lastly, we have to mention our work with our partners to assist us with our mission to provide the community with the tools and knowledge to live healthier lifestyles such as the student nurses volunteers. We have also provided incentives to increase involvement such as with translation

We want to also mention the contractor that have been instrumental in the implementation of the EHDI surveillance system and newborn screening database and the audiologist for the newborn hearing screening program. The procurement of contractors/consultants have assisted us to improve our data collection and service delivery.

//2012// The State budget has been in a deficit situation for several years. In October 2008

working hours was reduced from 80 hours to 72 hours. Then there was a government shutdown from October 1-4, 2010. To avoid layoffs, government workers are now working 64 hours every two weeks. There is a freeze in hiring thus the Division has not replaced locally funded positions when staff resigned or retired. All federally funded positions have been approved for hire by the Governor. There has been recruitment of college graduates which is a benefit for not just the MCH program but the Division as a whole in there is stability in the tenure of workforce. The Division recruited 3 staff for the new home visiting program. The CSHCN/EIS Program staffing decreased from 4 to 2 (1 retired and 1 resigned). There is currently 9 dental staff due to retirement of the dental assistant supervisor. There is also one staff providing support for administrative work at the Division/2012//

/2013/ Chief Executive Officer (CEO): Mr Juan N. Babauta was appointed CEO for the Commonwealth Healthcare Corporation by Governor Benigno Fitial in Octorber 2011. He received his M.S. in Health Planning/Health Services Administration from University of Cincinnati, Cincinnati, Ohio and his MA in Political Science/American History from Eastern New Mexico University, Portales, New Mexico. His political career includes: CNMI Governor from 2002-2006 and Senator -- 5th and 6th Northern Marianas Legislatures. He was a publisher and a writer for Homeland Magazine prior to his appointment.//2013//
/2013/ Director of Public Health Services: Ms. Roxanne Diaz was appointed Director in November 2011. She received her B.S. degree in Biology with a minor in Economics from Chaminade University, Honolulu, HI. She completed the Maternal and Child Health/Public Health Certificate Program from University of Hawaii. She is currently pursing an MBA from Loma Linda University. Prior to her appointment she was the Public Health Program Analyst/Special Assistant to the Secretary of Public Health at the former Department of Public Health.
/2013/Public Health Medical Director: Daniel Lamar, MD, graduated from the National College of Naturopathic Medicine (NCNM), Portland, OR ND in 1978 and the Oregon Health Sciences University (OHSU) Portland, OR MD in 1990. He completed his family medicine residency at Poudre Valley Hospital in Ft. Collins, CO. Dr. Lamar has worked in the CNMI since 1993.//2013//
/2013/Program Manager: Reyna Saures oversees the planning, implementation, and reporting requirements of the following Substance Abuse and Mental Health Services Administration (SAMHSA) grants: Strategic Prevention Framework State Incentive Grant (SPF SIG), the State Prevention Enhancement (SPE), and the prevention component of the Substance Abuse Prevention and Treatment (SAPT) Block Grant. Manages substance abuse program/community outreach on Saipan, Rota, and Tinian. Serves as the ex-officio for Substance Abuse Prevention on the Substance Abuse Prevention and Recovery Coalition (SAPARC), the community non-profit organization that networks with key substance abuse prevention, treatment, and recovery agencies, organizations, and community members to collectively address substance abuse issues in the CNMI.//2013//
/2013/Since FY 2011 work hours has been reduced to 64 hours. There is still a freeze in hiring thus the Division has not replaced locally funded positions when staff resigned or retired. The FTEs for the Home Visiting Program has been filled.//2013//

E. State Agency Coordination

The Commonwealth of the Northern Mariana Islands (CNMI) government is the provider of all state health and human services. Each state agency is under the supervision of the governor and is headed by a single executive. This include the Public School System, Department of Community and Cultural Affairs, CNMI Developmental Disabilities Council, Office of Vocational Rehabilitation, Nutrition Assistance Program, etc. Most of our work with other state agencies is through a Memorandum of Understanding/Agreement (i.e., Public School System) or serving as a member of a council or committee. As was mentioned in the organizational structure section, public health, mental health including alcohol and substance abuse, Medicaid and SCHIP, and hospital services are provided by the Department of Public

Health. There is only one government operated hospital in the CNMI -- the Commonwealth Health Center; Rota and Tinian have mini health centers. The Commonwealth Health Center (CHC) serves as the central acute care facility in the CNMI. Patients from Rota and Tinian are referred to CHC.

The Department's collaboration and partnership with other agencies, both public and private, is important to ensure the continuity of the delivery of services to the people of the CNMI. As has always been mentioned, the strength of the Program is in its work with partners that are committed and dedicated. Collaborative efforts in prevention and educational outreach activities among the programs within the Department are necessary to enhance the capacity of the MCH Program. This is one of the most critical components in the organizational relationships within the Division. As was mentioned in the Other (MCH) Capacity section, the staffing for the Health Education and Promotion involves all community outreach workers from all the programs. With the reduction in our budget this is one way to ensure that we are sharing and maximizing our limited resources.

//2012//The Department of Public Health includes the Division of Public Health, Hospital Division, and the Community and Guidance Center. As mentioned previously, the Commonwealth Health Center (CHC), government-operated facility, is the only hospital in the CNMI and located in Saipan; Rota and Tinian have health centers and patients from Rota and Tinian are flown to Saipan for mammogram, to deliver babies, dental care, etc. Majority of health and human services are provided through the Commonwealth of the Northern Mariana Islands (CNMI) government including the Public School System, Department of Community and Cultural Affairs, Northern Marianas College, Medicaid, and Office of Vocational Rehabilitation. All of the departments and/or agencies within the CNMI government have secretaries and/or directors that are appointed by the Governor and are all members of the executive cabinet.

To ensure the continuity of service delivery to the residents the three divisions at DPH must collaborate and partner with other agencies, both public and private. Collaborative efforts in primary and preventive services among the programs within the Department are necessary in its work for improved health and quality of life for the people of the CNMI. We have been mindful in our work to start shifting our focus on infrastructure building and this is evident with our work with the Nursing Assistantship Program with our partners. Federal funds have been used to support recruitment of staff, training with a focus on improved outcomes for MCH population groups, enhancing data infrastructure, public awareness and outreach activities, direct health care services, home visiting, etc.

Coordination within the Department of Public Health:
Medicaid: Our main coordination continues to be for CSHCN. To ensure that new applications and renewals are processed on a timely manner the Social Worker continues to be stationed at the Medicaid office to provide eligibility assistance for our families. In addition even with shortage of Medicaid staff (there is currently one staff that process application at the Medicaid Office) referrals by our providers are processed as priorities. Preventive health brochures are available to clients at the office. Our public awareness activities continue to include Medicaid Program information and participating private clinics information. Medicaid staff also participates in parent forums or committees. MCH Program and Medicaid are under the Department of Public Health (DPH).

Community Guidance Center (CGC): MCH Program staff participates in training opportunities coordinated by the Center such as the Suicide Intervention Workshop. In the CNMI Tobacco Prevention and Diabetes Prevention and Control Continuation Application one objective is "By March 2011, improve upon the existing referral mechanism for pregnant women with GDM and pre-existing DM and/or tobacco users [Work with MCH and DPH dietician to review existing referral mechanism to identify gaps; meet with Secretary of Health and Director of Medical Affairs to inform of findings as well as garner their support; revise and implement changes addressing identified gaps; inform and educate providers of new referral mechanism". We continue to bring

referral cards (especially for pregnant women) to the Center for the smoking cessation classes. The MCH Program Coordinator has been appointed to the Project Brabu Advisory Council with a focus on reducing underage drinking. We partner in our Autism Awareness campaign and coordinate activities for Children's Mental Health Day. CGC staff is a member of the Early Childhood Comprehensive System committee. Both are under DPH.

Hospital: Currently all women and children's health care including preventive care, is provided at the Women's and Children's Clinic at the hospital. The MCH Program continues to ensure 1) training in areas such as prenatal care, breastfeeding, and data collection; 2) availability of materials and resources; 3) public awareness activities; and 4) assist with referrals to other programs/agencies.

The Medical Referral Program: provides financial assistance for off-island medical care services for CSHCN. It facilitates the referral of clients to recognized referral health care facilities outside the CNMI for extended medical care. We work together in the coordination of referrals to places like Shriners' Hospital in Honolulu, Hawaii. Furthermore, we work to assist families with follow-up plan when they come back home. The Program is under DPH.

COORDINATION WITH OTHER DPH FEDERAL GRANT PROGRAMS
Title XX Family Planning (FP): We work with the program to ensure services at the school-based clinic and outreach activities especially for adolescents. The MCH Program Coordinator is a member of the FP Information and Educational Materials committee. We continue to be a referral source for the program.

WIC Program: One of our outcomes in our collaboration is the prenatal care classes. We continue to coordinate activities to improve breastfeeding rates; work together to assist with the nutritional needs of our CSHCN; and the fluoride varnish activity. We continue to be a referral source for the program.

MCH Program is working with the Breast and Cervical Screening Program, Comprehensive Cancer Control Program, and Diabetes Prevention and Control Program in the development of the Non-Communicable Disease work plan. The United States Affiliated Pacific Islands are in a regional state of emergency due to the onslaught of diabetes, cancer, heart disease and respiratory disease, according to participants in the 50th Meeting of the Pacific Island Health Officers Association (PIHOA).

Home Visiting Program: The MCH Program oversees our newest program in the Division. We have actively been involved with the writing of the application (grant narrative, needs assessment, and the supplemental information request). We will work in the coordination of home visiting services for families living in at-risk communities and activities for our priority needs.

COORDINATION WITH OTHER AGENCIES
Public School System -

- Early Intervention Services Program -- Through an MOU we coordinate public awareness and child find activities as well as service coordination.
- Newborn Hearing Screening Program: We continue with contractual services of Audiologist in which we screened 98% of newborns before hospital discharge.
- Oral Health: We continue to coordinate activities for the School Dental Program with the bussing of the children to the Public Health Dental Clinic. The schools works on the logistic portion including getting parent consent forms signed.

Northern Marianas College (NMC) -- As was mentioned in the State Overview narrative section, one of the Division of Public Health's initiatives is building local staff capacity. The Department collaborated with the Area Health Education Center in the Nursing Assistantship Program. We also coordinate activities with the college's Cooperative Research Education Extension Services in the area of nutrition. Nursing students continue to conduct screening during community events

for the Department.

Department of Community and Cultural Affairs (DCCA) -- Our coordination of activities has been enhanced with the new home visiting program. The Division of Youth Services and the Childcare Program were partners in the writing of the three narratives for the home visiting program. In May Ms. Penny Kyler conducted a site visit and they attended the stakeholders' meeting. We continue to coordinate parenting skills classes, events such as Week of the Young Child, and trainings.

Department of Commerce -- we work closely with the Central Statistics Unit in the area of data collection.

Workforce Investment Agency: This was one of our partners for the Nursing Assistantship Program.

COORDINATION WITH UNIVERSITIES AND ASSOCIATIONS
University of Hawaii Manoa and the Northern Marianas College: MCH Program Coordinator is a member of the Children's Healthy Living Program for Remote Underserved Minority Populations in the Pacific committee. Its goal is to build social/cultural, political/economic, and physical/built environments that promote active play and intake of healthy food to prevent childhood obesity in the Pacific region.

Pacific Islands Health Officers Association (PIHOA): One specific activity is the training on Public Health 101 for all Division of Public Health with a focus on enhancing staff knowledge and understanding of key public health principles and essential public health services. One of PIHOA's initiatives is to help the Pacific Jurisdiction

World Health Organization (WHO): The MCH Program has secured funding from WHO for training to public health dental staff for October 2011.

Commonwealth Diabetes Coalition: Our mission is to act as an advocate for public education and outreach into the CNMI Community at all aspects and on many levels. Its primary role is to increase our community's awareness of the serious impact of diabetes on our families; our social structure; our economy; and our people. It will increase awareness through public outreach and education programs in neighborhoods and schools. The ultimate goal is the development of programs successful in significantly reducing or eliminating diabetes as a health crisis in our islands as soon as possible.

Please note that as members of councils, advisory committees, boards, etc. we continue to coordinate and facilitate activities for MCH target population.//2012//

/2013/Being that most of our partners are agencies under the CNMI Government has made our work to coordinate activities for the MCH Program target group successful. Because we all are affected with the reduction of work hours and limited resources, especially with staffing, it has allowed us to evaluate our activities. One good example of this is the Week of the Young Child. This awareness event that focuses on early childhood combined the efforts of Head Start Program, Childcare Program, MCH and ECCS. In the past each of the programs would have its own early childhood awareness event. This event has provided another venue for the community to avail of the different services/programs each partner offers while at the same time navigating them to available community resources.
Coordination within the Commonwealth Healthcare Corporation
- ***Hospital Division -- provision of primary and preventive services. In addition, the providers assist the program in addressing emerging health issues for target group and also assist in outreach activities such as being presenters at conferences/symposiums and the Triple Treat Classes. The SSDI project coordinator is a member of the information technology for the Corporation.***

Coordination with other DPH federally funded programs

- ***NCD Bureau -- The Bureau was established to provide an organized platform and mechanism for a more collective and unified voice and effort in the delivery of resources against the main chronic diseases affecting the CNMI population, including mobilization of community partners and external entities impacting chronic diseases in a more cost effective and efficient manner. As a member of the NCD task force we are currently working on the CNMI NCD Strategic Plan. Our request for technical assistance on the life course model will assist the program and the Bureau in integrating chronic disease prevention into maternal and child health services.***
- ***Immunization -- oral health training, HPV campaign, and tracking Substance Abuse and Mental Health Program -- As May is Mental Health Awareness Month, the program takes the lead in facilitating and coordinating events for the community in which MCH participates. ECCS and MCH is the lead for Children's Mental Health Day. We refer to their tobacco quitline and smoking cessation classes. We also work with their project that addresses underage drinking.***
- ***WIC Program -- coordination of activities to increase breastfeeding rates. We have a group that are looking into making the Hospital Baby Friendly.***

Coordination with External Agencies
Public School System:

- ***EIS- provision of early intervention services for children 0-3 years of age. MCH is responsible to coordinate child find and public awareness activities***
- ***Head Start -- we coordinate oral health activities for Head Start children and families,***
- ***Hopwood Jr. High School -- PH and Dental staff received on-site training on educating and counseling adolescents on tobacco, betel nut and HPV infection and oral health. Staff was trained to screen for pre-cancerous lesions. For the training we worked with the students.***
- ***High Schools -- We are partnering with the Teen Talk Live group and they are currently providing feedback on the HRSA Personal Responsibility and Education Program application we are working to submit.***

Department of Community and Cultural Affairs

- ***Childcare Program -- continue with the annual health and safety training and in***
- ***Division of Youth Services -- working with home visiting for referrals and coordination and navigation of services for clients.***

Coordination with Universities and Associations

- ***CHC Volunteers Association: We work with the volunteers association in areas like fund raising. They also have assisted the program in the purchase of equipment for CSHCN Program.***
- ***Lions Club: The Lions Club assists us in our outreach work especially with bringing the community to our events. They also host events for children with special health care needs such as donating gifts at Christmas to our clients.***
- ***Northern Marianas College and University of Hawaii -- we continue with the Children Living in the***
- ***Pacific Islands Primary Care Association (PIPCA) -- provided a consultant to work with MCH Program Coordinator in the writing of the oral health grant narrative. They also sponsored the Primary Oral Health Training.///2013//***

F. Health Systems Capacity Indicators

2013/ The Health System Capacity Indicators provide useful measures of important MCH issues. The Program has been increasing its efforts every year to address disparities in utilization of preventive services by Medicaid enrollees. Some of these efforts include provision of eligibility

assistance, putting Medicaid information and names and contact of Medicaid participating private clinics in all awareness campaigns, distribution of brochures on importance of preventive services, sharing of information, etc. It has allowed for discussions with our partners such as Head Start Program on how to help our clients. One of the topics presented during the in-services for Head Start teachers was on asthma. The review of the data directs the Program's ability to maintain or improve the HSCIs. The data shows our success in our work and provides direction to other opportunity/strategies to help improve indicator outcomes. We are still challenged with getting Medicaid data although as a program we have provided some funding for their data system, made SSDI Project Coordinator work with them, and provide staffing to assist in the processing of applications. Interpretation of the data includes collaboration between program staff, data staff, and partner programs. The training of an MCH staff in performance improvement activities will improve the capability to provide a story to the number for our target group. We are currently working with the Vital Statistics Office and the Labor and Delivery Unit to enter birth certification information electronically instead of writing into a logbook. We are working to improve the quality of data we collect so that we may use the indicators as a surveillance monitoring tool to impact health outcomes and report the trends to all partners.//2013//

IV. Priorities, Performance and Program Activities

A. Background and Overview

The continual decrease in Department of Public Health's budget has moved the Maternal and Child Health program and other programs at the Division of Public Health to expand its collaborations to other resources. Specific program activities are developed and categorized by the four service levels found in the MCH Pyramid: direct health care services, enabling services, population-based, and infrastructure-building. We allow for flexibility in implementing activities to address emerging priority need such as H1N1.

As programs we are considerate of the financial situation of families. Through our work with village projects we know that if we bring the service to them they will come. This also helps progress in our efforts to reduce health disparities. Immunization is provided at Children's Developmental Assistance Center and at Head Start centers. Fluoride varnish and sealant application is conducted also at Head Start centers, WIC and Immunization clinics. We provide our partners with information such as 'talking points' for them to avail the opportunity to talk about general preventive health screenings to their target group. In addition, the information is also in our awareness media campaign which includes print, radio spots and tv. Developmental screening is provided free one Saturday a month and also at Immunization clinic as an activity to increase referrals to early intervention services program. Our work with school-based clinics meets the students in their environment thus creating trust with us as service providers in teen pregnancy and STD prevention. We continue providing women's health exam in partnership with Breast and Cervical Screening Program and Wise Women Village Project out in the villages. Because the most prevalent cancers in women in the CNMI are those that could be prevented and/or cured with early detection and treatment, we worked to overcome cultural and financial barriers and educate women on the importance of screening. Access to pap test and mammogram has been identified as priority needs by our women.

Although we have met the objectives on most of the national and state performance measures, we continue to be challenged by low prenatal care rates, high dental caries among Head Start children, lack of data, inability to access data, etc.

In looking at the expenditures and budget for the MCH Program, we continue to use majority of the funds for direct health services. This is a reflection of the decreased in budget for the Department as a whole. Again, the program continues to also work with other programs that can provide direct health services while we focus on the other three service levels of the MCH pyramid.

/

/2012// The MCH Program seeks to improve and enhance the health of women, infants, and children including those with special health care needs through funding of Title V, other federally funded partner programs and state supported activities and programs. In compliance with GPRA, the following progress report on the Maternal and Child Health National and State Performance Measures is presented annually. The measures are reviewed by the Types of Service as shown in the pyramid in Figure 1 in the guidance. Specific program activities are described and categorized by the four service levels of the MCH pyramid - direct health care, enabling, population-based, and infrastructure building services. We examined capacity/strengths, weaknesses/challenges and opportunities for each level of the pyramid for each priority need identified. The MCH needs assessment was designed to be population-based, community focused, and framed within a family context. The MCH Program established an MCH Needs Assessment working committee to assist in the oversight and direction of the needs assessment. MCH Program Coordinator and staff continue to address action plan for the priority needs with stakeholders. For example, in our meetings with stakeholders/partners on the priority need for CSHCN we went back to what actually needs to be done to improve outcomes which is early identification and early intervention. Because of lack of data on childhood obesity other than WIC data, the working group decided to adopt Healthy People 2020 objective for our priority need with

a focus on improved nutritional status for children aged 0-5 years. The program activities or the role of MCH in the implementation of each performance measure varies such as to provide, ensure/assure, advocate, supplement, lead, etc. While there is still a broad emphasis on ensuring access to quality and affordable health care and the elimination of health disparities, we have seen a shift of resources to address global threats to public health. We have participated in emergency preparedness exercises, is a member of the non-communicable disease task force, and participated in community wide immunization outreach.

Our state performance measures focuses on prenatal care, breastfeeding, nutritional status, adolescent risk behavior, teen births, enhanced early identification of developmental delays, including autism. We still are challenged with a health information system that has not had updates due to lack of funding for the past 13 years.
To reiterate, the strength of our work is in our collaboration with all our partners.//2012//

/2013/ The CNMI Government's revenues have fallen drastically causing the CNMI's annual budget to drop 56% -- more than $90 million dollars -- over the last 12 years. Since the CNMI health care system is dependent on government funding, public health services have suffered as its budget has been cut again and again. Thus, federal public health grants have been instrumental in providing the needed resources to build capacity for the priority goals and objectives. This not only includes MCH funding but also early childhood funding, health information technology funding, substance abuse and mental health funding, home visiting, NCD funding, etc. MCH program staff is a member of the NCD taskforce and works with its partners to revised the NCD strategic plan that will address obesity prevention and intervention. Adequate resources in the community, at schools, and at worksites are needed to bridge gaps and inequities for linking families to information and services they need to establish healthy and safe families. Home visiting services and supports need to improve policy and program coordination at the state level to better support outreach and linkages for families to appropriate resources and programs. We continue to examine opportunities for each of the priority in the four levels of the pyramid to support and enhance the provision of primary and preventive services to improve health outcomes for the MCH target group.//2013//

B. State Priorities

The priority needs for the CNMI MCH Program focuses on getting the community's input as to what are needs for each specific MCH population groups. MCH Program collaborated with community members such as women's group, parents, pregnant women, parents of CSHCN and internal and external partner to identify state priority needs. We reviewed information such as health status indicators, performance and outcome measures, resources and capabilities for the MCH Program and the Department of Public Health in general. In assessing the capacity the weakness is that the MCH Program worked with internal partners only in identifying strengths, challenges, and opportunities to provide services/activities/initiatives for each need.

SPM#1: The percent of unplanned pregnancies for women aged 15-44 years.
Reducing unplanned pregnancies is possible and necessary. The result of unplanned pregnancy is that the mother is less likely to seek prenatal care during first trimester and less likely to have any prenatal care. The child of such a pregnancy is at greater risk of low birth weight and other complications. Last year 75% of live births were unplanned. Last year a survey was conducted to evaluate access to prenatal care. One hundred thirty-one surveys were obtained. Twenty women gave the reasons for not receiving adequate care is because they were unaware they were pregnant. Pregnancy test kits are available at all public health clinics. With the revision of the birth certificate to the 2003 standard form, we are looking to review birth outcomes and unplanned/planned pregnancies. DPH applied for the ACA Home Visiting Program and we will work with these mothers to ensure that they access preventive health screenings for both themselves and their babies.
We continue to work with the Family Planning (FP) Program for counseling, education,

contraceptives, fee waiver for adolescents. We continue to send staff to participate in the Title X Pacific Basin FP conference. Two local nurses are certified women's health nurse practitioners and are providing services at school-based and satellite clinics. This activity is related to NPM#8 and #18 and SPM #7. Activities can also focus to working with mothers for infants screening such as NPM#1; #7; #11; #12; #14 and #15.

SPM #2 Percent of women who ever received a pap test.
In the September 2004 issues of Pacific Health Dialog, a 10 year study (1991-2001) of cancer among women in the CNMI shows that of the 304 cancer 29% were breast cancer and 20% were cervical cancer. Six women are diagnosed with cancer every year in the CNMI. There were 15,543 women aged 25-60 years that were identified as not having had a pap smear for the past 4 years in 2004. The MCH Program partners with the BCCSP (Breast and Cervical Cancer Screening Program) to increase access to pap services and awareness and outreach activities. In 2005 it partners with the Wise Women Pap Project in which women on the list were scheduled to come for free well-women exams during the evenings at the Women's Clinic. As partners we saw the need to implement gender-focused free preventive health screenings, community education, and medical management and so we submitted the ASSIST 2010 grant application with the lead of the nurse midwife to implement Wise Women Village Project (WWVP). We have been collaborating with 2 private clinics to provide this service to these identified women. The target population for the MCH Program is all women whereas the target group for BCSP has to fall within the program's eligibility guidelines and the target group for WWVP is local indigenous women. Therefore, we refer women (especially those with no insurance) that qualify for these programs and MCH provides the support for outreach and awareness activities. In addition, we provide staffing for the two initiatives. We have focused activities for Women's Health Week on going to government agencies to educate women on importance of pap test and provide the services in our mobile clinic. We get assistance on case management for abnormal test results from BCSP. A major intervention activity for WWVP is participant education regarding physical activity, BMI, nutrition, and tobacco cessation counseling. We provide educational materials to private clinics for their Medicaid clients.
These activities are related to NPM#15, #18, and SPM#1, #2, #3 and #6.

SPM#3:Percent of women who have ever received a mammogram.
Of the 304 cases of cancer in females from 1991-2001, 29% were breast cancer. Findings suggest that cancer is the second-leading cause of death in CNMI. Because the most prevalent cancers in women in the CNMI are those that could be prevented and/or cured with early detection and treatment, we must overcome cultural barriers and educate women on the importance of screening and in making sure that they have access to these screenings. Clinical breast exam is one of the preventive health screening provided at the village project and the evening clinic. Women needing mammography services are referred. We have focus activities for Women's Health Week on going to government agencies to educate women on self breast exams and have providers also conduct clinical breast exam. We provide magnets on when to get women's health screenings during this week. The cost of cancer screening tests and the lack of radiologist continue to be significant barriers. We provide educational materials to private clinics for their Medicaid clients.
These activities are related to NPM#15, #18, and SPM #1, #2, and #6.

SPM#4: Percent of eligible infants with disabilities under 1 year receiving early intervention services.
The CNMI provides early intervention services (EIS) to infants and toddlers, birth through age three, and their families in collaboration with the Public School System (lead agency) since 1986. This is the entry point for children identified with special health care needs. Majority of the children being referred to the EIS program is mostly older than 1 year of age. There are 54 children enrolled in the EIS Program in which 1% is under one year of age. The program received 79 referrals last year in which 22 were under the age of 1. 41% of our referral source is from the NICU at the hospital, 29% from the PH facilities, and 10% from parent/family. We will continue with our work to emphasize early identification and early intervention for this target

population using interdisciplinary team approach. We continue to provide general health information in the prenatal care packet and Early Intervention Services program packet. We collaborate with Immunization program to put developmental screening information on the new shot record. The CSHCN Coordinator works with EIS Program staff in child find and public awareness activities including Medicaid participating private health clinics. We have increased conducting developmental screenings to one Saturday a month, and at WIC and Immunization Clinics. We also are working with daycare centers. In the 2010 Head Start Community Needs Assessment two priorities are increase numbers of children being identified as having developmental delays or disabilities in early childhood and increase the number of children screened for autism and language and speech disorders.
These activities are related to NPM#1-6, #8, #12, #13, #18 and SPM#1 and #7.

SPM#5:The rate of Chlamydia for adolescents aged 13-17 years.
In the 2007 YRBS survey results show that the percentage of high school students who ever had sexual intercourse was 49.7 and 18.4 for the middle school. The percentage of high school students who used a condom during last sexual intercourse went from 43.1 in 2005 to 40.1 in 2007. The percentage of high school students who had sexual intercourse with 4 or more people during their life was 19.6. At the school-based clinic gonorrhea and chlamydia testing is provided with approximately 10% of tested students coming up positive for chlamydia. Data from the Hospital's lab unit shows that out of 103 tested for chlamydia for this age group 15 were positive. Adolescents can also access testing at other public health clinics including the HIV/STD Resource and Treatment Center. MCH collaborates to provide testing, medications, tracking, outreach activities and presentations at the schools and community events. Condoms are available for free at all the PH clinics. We are also partnering with another public high school that opened a health center and recruited a nurse last school year.
These activities are related to NPM#8, and SPM#1, #2 and #7.

SPM#6:The degree to which State provides nutrition education information to students aged 6 through 11 years.
The CNMI ranked third in the world for prevalence of Type II diabetes. Obesity has been growing at a fast pace in the CNMI. The rates are higher than those of the US mainland, and this is evident when looking at any typical classroom. Head Start data (p. 400) from School Year 07-08 indicated that 14.3% of children are at risk of overweight (85th-95th%), and 17.5% of children are already overweight (>95th %). The percentage of children, ages 2 to 5 years, receiving WIC services with a Body Mass Index (BMI) at or above the 85th percentile was 25.9. In 2005 the Healthy People Living in the Pacific Islands survey was conducted to 420 children 6 months to 10 years old. Using CDC cut off points, 34% of the children in the survey were found to be at risk for overweight. For those aged 5 to 10 years, 68% has no physical activity outside of school. Some of our collaboration includes Cooking Shows/demonstrations, Healthy Snacks Recipe, bottle weaning, and breastfeeding. The nutritionist is the most requested speaker/presenter at the elementary schools. In collaboration with ECCS, we have provided incentives to children to increase physical activity such as jump ropes and Frisbees. We encourage family participation in DPH village exercise/dance classes.
These activities are related to NPM#11 and #14.

SPM#7:Percent of pregnant women who are screened for Chlamydia.
Our main focus is to increase the awareness of early and continuous prenatal care visits which will make sure that all pregnant women come in early for prenatal care and gets screened. STD information is available in the prenatal care booklet. Additional information is included in the prenatal care packet. We collaborate with HIV/STD Prevention Program for training including CTR and for counseling and partner tracking with their STD case worker. We continue collaboration with other programs in providing free STD testing and medications for indigent women of childbearing age and their partner(s). We are working with other programs to recruit one staff to be stationed at Lab Unit to enhance our tracking. STDs brochures are provided to clients and available at all clinics in the CNMI, including private.
These activities are related to NPM#8, #18 and SPM #5.

The following are the new State Performance Measures
Pregnant Women and Infants
Initiation of prenatal care visits during first trimester for pregnant women enrolled in the Medicaid Program.
Related to NPM #18 -- Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester

Improved case management of pregnant women identified a "high risks"
Related to NPM # 15 -- Percentage of women who smoke in the last three months of pregnancy

Initiation of breastfeeding at hospital discharge
Related to NPM #11 -- The percent of mothers who breastfeed their infants at 6 months of age

Percent of women who ever received a pap test.
These activities are related to NPM#15, #18, and SPM#1, #2, #3 and #6

Percent of women who have ever received a mammogram
These activities are related to NPM#15, #18, and SPM #1, #2, and #6.

Children and Adolescents
Developmental screening for children 0-5 years

Improve nutritional status and physical activity in children
Related to NPM #14 - Increase the proportion of primary care physicians who regularly assess body mass index (BMI) for age and sex in their child patients aged 2-5 years.

Decrease teen birth of Chamorro teenagers aged 15 through 18 years
Related to NPM #8 - The rate of birth (per 1,000) for teenagers aged 15 through 17 years

Reduce adolescent risk behaviors relating to alcohol and other drug use

Children with Special Health Care Needs

Input infants with a "diagnosis" into the birth defects database with 6 months of diagnosis
//2012//The CNMI's priority MCH needs for 2011-2015 are:

#1. Increase initiation of prenatal care visits during first trimester for pregnant women enrolled in the Medicaid Program: Overall prenatal care rate is low in the CNMI. Moreover, survey results show that women enrolled in the Medicaid Program also do not access early and continuous prenatal care. The system is in place to provide prenatal care services to Medicaid enrollees however it is not utilized. MCH program can provide eligibility assistance and thus this will provide the uninsured the opportunity to apply for Medicaid. Partners such as Head Start and Early Intervention Services want to improve health outcomes for their target population. MCH needs to provide information on services covered by Medicaid Program because as one mother said -- "I thought it only covers for my baby's cost".

#2. Improved case management of pregnant women identified as "high risks": In our discussions with women prevention of diabetes was a priority. The working group looked at existing programs both at the Department of Public and other agencies and their capacity to address this issue. In November last year MCH worked with a consultant to assist the program look at the problem of gestational diabetes. Her scope of work was to identify GDMs and pregnant women with pre-

existing diabetes and to design and implement case management services for these women. From December 2009 to May 2010 there were 39 women identified. We are working to improve case management by revising policies, reinstating glucometer loaner program, training to providers and nurses for counseling and education, referral to WIC Program, etc.

#3. Increase breastfeeding at hospital discharge: Obesity, diabetes, hypertension, and atherosclerotic vascular disease are among the major health concerns facing the CNMI population. Research has shown benefits of breastfeeding for babies such as it may protect them from obesity later on in life; may protect them from developing type 1 diabetes; and protection against heart diseases. Moreover the benefits to the mothers include decreased risks of osteoporosis, breast and ovarian cancers, and type-2 diabetes. The working group was presented with WIC Program's breastfeeding data but with information/knowledge on the benefits of breastfeeding, morbidity and mortality data, it was ranked high and thus was selected. Furthermore, there is added support from partners in this area to put more efforts into this intervention which is of no cost to families.

#4. Increase the proportion of primary care providers who measure the body mass index (BMI) for age and sex in their children aged 0-5 years: The challenge for decreasing obesity in children is that we have no data other than WIC Program's data and survey data that were conducted about 6 years ago. I met with partners that included parents and it was decided to adopt one of healthy people 2020's objectives on improving children's nutritional status. Please note that although we have conducted activities on nutrition and physical activity, I met with the working group in late April.

#5. Decrease teen birth of Chamorro teenagers aged 15 through 18 years: The results from the Adolescent Health Determinant work group identified teen pregnancy as a priority need. They ranked it second amongst the list. In reviewing the data, the working group focused it to reducing the birth rate among Chamorro teenagers since they have the highest rate. They chose ages 15-18 because majority of 18 year olds are still in their last year of high school.

#6. Reduce adolescent risk behaviors relating to alcohol and other drug use: The results from the Adolescent Health Determinant work group identified alcohol and other drug use as the important/most common and/or most concerning adolescent issues related to 1) Behaviors that contribute to unintentional and intentional injuries; 2) Sexual activity that leads to unintended pregnancy and sexually transmitted diseases 3) Mental Health and 4) Alcohol, Tobacco, and other drug use. Furthermore, students ranked alcohol and other drug use the highest amongst the list of priority needs.

#7. Enhance early identification of developmental delay, including autism: The priority need that was identified by parents, partners, and rank is early identification and intervention of infants with special health care needs. This priority area is similar to the previous needs assessment in that we focused our work on making sure that infants are referred for early intervention services before 1 year of age. Early intervention (before school age) can have a significant impact on a child's ability to learn new skills as well as reduce the need for costly interventions over time. Early intervention services help children from birth to 3 years old (36 months) learn important skills. EIS program can also evaluate for autism.//2012//

C. National Performance Measures

Performance Measure 01: *The percent of screen positive newborns who received timely follow up to definitive diagnosis and clinical management for condition(s) mandated by their State-sponsored newborn screening programs.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective	97	98.5	98.5	100	100
Annual Indicator	0.0	100.0	100.0	100.0	100.0
Numerator	0	1	2	1	1
Denominator	1385	1	2	1	1
Data Source		Lab	Lab	Lab and Metabollic Screening Database	Metabollic Screening Registry
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.			Yes	Yes	Yes
Is the Data Provisional or Final?				Final	Final
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	100	100	100	100	100

Notes - 2011
Please note that due to lack of budget the lab we were working in suspended the service until payment is received. We are looking at strategies to bring back this service. There were no newborn screening conducted in 2011. The only other private lab does not perform this service.

Notes - 2010
There were 954 babies that receive screening for 7 disorders. This accounts for 89% of live births. We have 1 confirmed case (anemia). in 2010.

Notes - 2009
There were 2 positive metabolic screening for GALT and Hemoglobin, both received treatment. Need to verify kind of treatment.

a. Last Year's Accomplishments
-In 2011 there were no newborn screenings conducted. The then Department of Public Health had pending balance with Oregon State Public Health Laboratory and thus services were stopped. The only private laboratory on Saipan does not perform newborn screening.
-Modify database to work with the development of the new electronic record exchange system, which is called States and Territorial Exchange of Vital Events (STEVE).
- Training of MCH staff to generate monthly reports from the newborn screening database

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	**ES**	**PBS**	**IB**
1. Medical Director is the lead in addressing the current situation of babies not being screened.	X		X	X
2. Maintenance of database linking newborn screening records with birth certificate database.			X	X
3. Newborn screening brochures included in prenatal care packet		X	X	
4.				

5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The medical director has been involved with coming up with solutions to continue with newborn screening. Some of these are:

1. We have information for the Philippine Lab that the Republic of Palau sent their specimen but it is not a U.S. certified lab and thus the Department could not go that route.
2. We have been in discussion with a new laboratory that opened in April of this year about the capability of performing this service and they are looking into it
3. Building the capacity of the Corporation's laboratory including staff to perform this service.
4. MCH funds to be used for training and sliding fee scale (working on ensuring that all fees collected from this service go back to MCH Program funds

c. Plan for the Coming Year

-Ensure that once Corporation's financial system is in place that any MCH funds used to support services for target group is returned back to the program to assist with sustainability.
-Work with programs such as WIC and Home Visiting to assist with tracking efforts
-Work with FQHC's Kagman Community Health Center to include newborn screening services including tracking

Form 6, Number and Percentage of Newborns and Others Screened, Cases Confirmed, and Treated

The newborn screening data reported on Form 6 is provided to assist the reviewer analyze NPM01.

Total Births by Occurrence:	**1033**					
Reporting Year:	**2011**					
Type of Screening Tests:	**(A) Receiving at least one Screen (1)**		**(B) No. of Presumptive Positive Screens**	**(C) No. Confirmed Cases (2)**	**(D) Needing Treatment that Received Treatment (3)**	
	No.	%	No.	No.	No.	%
Phenylketonuria (Classical)	0	0.0	0	0	0	
Congenital Hypothyroidism (Classical)	0	0.0	0	0	0	
Galactosemia (Classical)	0	0.0	0	0	0	
Sickle Cell	0	0.0	0	0	0	

Disease						
Hearing Screening	1013	98.1	9	1	1	100.0

Performance Measure 02: *The percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive. (CSHCN survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	87	88	88	88	59
Annual Indicator	87.0	87.0	59.0	59.0	59.0
Numerator	147	147	79	79	79
Denominator	169	169	134	134	134
Data Source		CSHCN survey	CSHCN survey	CSHCN survey	CSHCN survey
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	59	59	60	60	60

Notes - 2011
In the 2010-2011 Family Survey conducted by the Early Intervention Services Program 92% of participants said they know their rights and 93% said they effectively communicate their children's needs.
We are in the process of printing the 2012 survey. We will be conducting it from September to December 2012. We will report survey results next year.

Notes - 2010
We plan to conduct the survey every 3 years which will be in 2012 so we will be using same data at past 2 years. In the 2009-2010 Family Survey conducted by the Early Intervention Services Program 94% of participants said they know their rights and 93% said they effectively communicate their children's needs.

Notes - 2009
CSHN Survey 2009
175 were respondents
134 were qualified

a. Last Year's Accomplishments
- Modify database to work with the development of the new electronic record exchange system, which is called States and Territorial Exchange of Vital Events (STEVE)
-Train MCH staff on database to generate monthly reports
- Participated in community outreach programs (Week of the Young Child, Childhood Obesity Awareness, etc)
-Set up outside of shopping centers and pass out developmental checklists and brochures

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Revised survey questionnaires		X	X	X
2. Process forms for printing of survey		X		
3. Meetings with Public School System Special Education Program, Head Start Program, and Early Intervention Services Program regarding survey		X	X	
4. Staff meeting on conducting survey		X	X	X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

-Review CSHCN survey questionnaires
-Staff meeting on conducting CSHCN survey by December 2012
-Referral to early intervention services and specialty clinics
-Work with partners such as Public School System on parent events/training
-Work with partner programs on family surveys and evaluations
-Continue to provide interpreters and transportation as requested
-Conduct presentation on Early Intervention Services Program at Nurses' Week, providers meetings, private clinics, and also to high school students during career day on related services field -- i.e., physical therapy
-Collaborate with partners on family/parents events such as Public School System
-Provide input on the Autism Awareness
- Visit NICU, NSY, and PEDS; give new parents folders about program and developmental information.

c. Plan for the Coming Year

-Meet with partners to discuss CSHCN survey including parents
-Conduct Public Service Announcements on the survey
-Conduct CSHCN survey
-Participate in other programs that address career opportunities -- i.e., Summer Camp
-Implement Telehealth

Performance Measure 03: *The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective	69	69	70	70	26.9
Annual Indicator	68.0	68.0	26.9	26.9	26.9
Numerator	115	115	36	36	36
Denominator	169	169	134	134	134

Data Source		CSHCN survey	CSHCN survey	CSHCN survey	CSHCN survey
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	26.9	27	27	27	27

Notes - 2011
We will be conducting the 2012 survey from September to December.

Notes - 2009
53 within medical home. 36 received coordinated, ongoing, comprehensive care.

a. Last Year's Accomplishments
-Modify birth defects database
-Recruitment of service coordinator

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Continue with referrals to private health and dental clinics with Medicaid participants	X	X	X	
2. Continue with awareness campaign for EIS/CSHCN that includes information on Medicaid Program and private clinics		X	X	
3. Continue to station Social Worker at Medicaid Program once a week to process new applications and renewals for CSHCN and families		X	X	X
4. Continue to work with Shriner's Honolulu Hospital for orthopedic needs of CSHCN -	X	X	X	X
5. Continue with child find and public awareness activities		X	X	
6. ASQ developmental screening tool implemented at the Early Intervention Services Program	X	X	X	X
7. Presentations on program and career opportunities conducted at events such as schools career days, summer camps, etc		X	X	
8.				
9.				
10.				

b. Current Activities
-Continue with referrals to private health and dental clinics with Medicaid participants
-Continue with awareness campaign for EIS/CSHCN that includes information on Medicaid Program and private clinics
-Continue to station Social Worker at Medicaid Program once a week to process new applications and renewals for CSHCN and families
-Continue to work with Shriner's Honolulu Hospital for orthopedic needs of CSHCN
-Continue with child find and public awareness activities

-Generate monthly reports from the birth defects database for referral to early intervention services
-Provide training such as "Developing Measurable Goals" and others to maintain certification requirements for EI providers
- Implemented the ASQ developmental screening tool at the Early Intervention Services
-Presentations on program and career opportunities conducted at Professional Staff Development event

c. Plan for the Coming Year
-Have Home Visiting Program staff be trained on eligibility assistance
-Refer to Home Visiting Program as needed
-Train child care settings providers on the ASQ developmental screening tool
-Implement Telehealth
-Implement ASQ developmental screening tool at the Children's Clinic

Performance Measure 04: *The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	69	70	70	70	59
Annual Indicator	68.6	68.6	59.0	59.0	59.0
Numerator	116	116	79	79	79
Denominator	169	169	134	134	134
Data Source		CSHCN survey	CSHCN survey	CSHCN survey	CSHCN survey
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	59	59	60	60	60

Notes - 2011
We reviewed insurance status of children enrolled in EIS and 89% of all children are Medicaid enrollees. In addition out of 96 records we reviewed for the Shriners Clinic, 73% are Medicaid enrollees. There are no uninsured in EIS and 11 of the 96 records we reviewed for Shriners Clinic are uninsured. We included again the question of “Does your child’s health insurance pay for off-island costs?” on the 2012 CSCHN survey

Notes - 2009
134 respondents
112 were qualified
79 have adequate insurance to pay services they need

a. Last Year's Accomplishments
-Ensure that information on insurance is collected at EIS/CSHCN program

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continue with referrals to Medicaid participating private health and dental clinics	X	X	X	
2. Medicaid Program and Medicaid participating private clinics information included on all awareness/outreach materials		X	X	
3. Social Worker stationed at Medicaid Program once a week to process new applications and renewals for CSHCN and families		X	X	
4. Continue with referrals to Medically Indigent Assistance Program		X	X	
5. Continue to provide interpreters and transportation as requested		X	X	
6. In discussion with Shriners Hospital on assistance with travel expenses of clients	X	X	X	X
7.				
8.				
9.				
10.				

b. Current Activities
-Continue with referrals to Medicaid participating private health and dental clinics
-Medicaid Program and Medicaid participating private clinics information included on all awareness/outreach materials
-Social Worker stationed at Medicaid Program once a week to process new applications and renewals for CSHCN and families
-Continue with referrals to Medically Indigent Assistance Program
-Continue to provide interpreters and transportation as requested
-In discussion with Shriners Hospital on assistance with travel expenses of clients

c. Plan for the Coming Year
-Have Home Visiting Program staff be trained on eligibility assistance

Performance Measure 05: *Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective	45	46	46	46	52.2
Annual Indicator	43.2	43.2	52.2	52.2	52.2
Numerator	73	73	70	70	70
Denominator	169	169	134	134	134
Data Source		CSHCN survey	CSHCN survey	CSHCN survey	CSHCN survey
Check this box if you cannot report the					

numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	52.2	53	53	55	55

Notes - 2011
From the EIS Family survey, 74% has written comments regarding their positive experiences with the EIS Program – "The staff are very accommodating to our child's and family needs. They are patient with
our child and has helped him move forward on his language delay"; "They help us understand our child's medical needs"; and "Some positive experience my family has had with the early intervention service are social emotional need/ ways to meet children's needs, to feel safe and secure, to feel worthy and loyal, to feel acknowledg

Notes - 2009
134 respondents
50 reported community based service are organized

a. Last Year's Accomplishments
-MCH Program, EIS, Home Visiting, etc included in partners resource directory
-Provided information for the Autism in the CNMI report

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Continue to work with parent groups such as Autism Society		X	X	
2. Members of committee such as Head Start Program's Community Partner		X	X	X
3. Surveyed EIS/CSHCN clients on what community-based services they use			X	
4. Brochures on MCH programs including educational information on prenatal care, immunization, etc. provided to day care centers, Medicaid program office, and private clinics		X	X	
5. Continue to participate in partners/community events		X	X	
6. MCH Program information included in partners' resource directory		X	X	
7.				
8.				
9.				
10.				

b. Current Activities
-Continue to work with parent groups such as Autism Society -Members of committee such as Head Start Program's Community Partner
-Surveyed EIS/CSHCN clients on what community-based services they use
-Brochures on MCH programs including educational information on prenatal care, immunization, etc. provided to day care centers, Medicaid program office, and private clinics
-Continue to participate in partners/community events

-Help families navigate other state programs
-Conduct program presentation during Nurses Week, Other partners staff professional development day including the Divisions under the Corporation (Attach is pictures during one of our presentations. We also invite our partners to talk about the work we do during these presentations)
An attachment is included in this section. IVC_NPM05_Current Activities

c. Plan for the Coming Year
-Partner with Home Visiting Program to ensure coordination of services for CSHCN and their families
-Work with FQHC - Kagman Community Health Center - for referrals of clients

Performance Measure 06: *The percentage of youth with special health care needs who received the services necessary to make transitions to all aspects of adult life, including adult health care, work, and independence.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	7	7	8	8	6.7
Annual Indicator	5.9	5.9	6.7	6.7	6.7
Numerator	10	10	9	9	9
Denominator	169	169	134	134	134
Data Source		CSHCN survey	CSHCN survey	CSHCN survey	CSHCN survey
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	6.7	7	7	8	8

Notes - 2011
We again include the question “Does your child’s health care provider discussed transition from pediatrician to adult provider”? in the 2012 CSHCN survey we will be conducting.

Notes - 2010
One survey question was asking if child health care provider has discussed the move to adult provider and all 9 participants that have YSHCN said no. One of our activities is to work with providers to create a written transition health care plan.
We have plans to conduct another survey in the last part of 2012 so our numbers will next year will still be the same.

Notes - 2009
131 respondents
9 received services to make transitions to aspects of adult life

a. Last Year's Accomplishments

-Participated in development of Developmental Disabilities State Plan

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Include transition of youth to adult life in Developmental Disabilities Council State Plan -		X	X	X
2. MCH staff member of IEP team (on a request basis)			X	
3. Participate in Assistive Technology conference and provide awareness on availability of resources – both financial and assistive devices		X	X	
4. Conduct CSHCN survey		X	X	X
5. Provide information to Developmental Disabilities Council Trankilu Loan Program		X	X	
6.				
7.				
8.				
9.				
10.				

b. Current Activities

-Include transition of youth to adult life in Developmental Disabilities Council State Plan
-MCH staff member of IEP team (on a request basis)
-Participate in Assistive Technology conference and provide awareness on availability of resources -- both financial and equipment for assistive devices
-Conduct CSHCN survey
-Provide awareness to the Trankilu Loan Program - provide loans for people with disabilities on assitive devices
-Attended Pac Rim conference

c. Plan for the Coming Year

-Work with Co-op Program at the Public School System and Workforce Investment Agency to encourage private sector to hire youths with special needs

Performance Measure 07: *Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective	75	88	88.5	88.5	77
Annual Indicator	76.9	77.1	86.8	77.0	87.2
Numerator	1109	1125	1386	1091	1306
Denominator	1442	1459	1596	1417	1498
Data Source		Immunization Registry	Immunization Registry	Immunization Registry	Immunization Registry
Check this box if you cannot report the numerator because					

1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Final
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	88	88	89	90	90

Notes - 2011
The Immunization walk-in clinic is open Monday to Friday including lunch hours.

Notes - 2010
The reduction in hours contributes to the decrease in numbers. The Immunization Program has increased their awareness campaign and started providing gas vouchers as incentives for parents to bring in their children for immunization. They have plans to bring the services out to the villages.

Notes - 2009
1386 children aged 19-35 months completed Immunization screening in 2009.

a. Last Year's Accomplishments
-Conducted aggressive campaign to raise our coverage rates and educate the community on Public Law 6-10 (Immunization Law). See Attached.
-Generated a list of children aged 0-18 who are delinquent with their shots to identify those children who are "MOGE" (moved or gone elsewhere). Once these children are identified they are marked as "inactive" in our system.
- Immunization Program has distributed quarterly reminder letters to students and their parents in order to inform them that their child is delinquent.
-Immunization staff has been meeting with parents and school officials when possible (PTA meetings, principals meetings, etc) to discuss the immunization requirements in order to educate and give advance warning that the law will be enforce for 2011-2012.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Brochure on age appropriate immunization and Public Law 6-10 (Immunization Law) included in schools' registration packets		X	X	
2. Open walk-in clinic Monday to Friday including lunch hour	X	X	X	X
3. Identify children that are not up-to-date		X	X	
4. Conduct Immunization awareness campaign that include Public Law 6-10 especially the enforcement component		X	X	
5. Meetings with schools and parents regarding PL 6-10		X	X	
6. In discussion with public and private schools to establish an MOU to allow Public Health to vaccinate children that are not up-to-date on campus		X	X	X
7. Continue with incentive program		X	X	

8.				
9.				
10.				

b. Current Activities

-Continue with media campaign that includes information on Public Law 6-10, how vaccines work, etc.
-Continue with incentive items such as school supplies, gas coupons, gift certificates, and story books/coloring books.
- Working to establish an MOU with both public and private schools that will allow Immunization Program to vaccinated delinquent children on campus.
-Provide to schools an immunization packet that will be included with the registration packet given to parents before they register their children in school. The immunization packet will contain information on vaccines and Public Law 6-10 (immunization law).
-Immunization clinic hours have been expanded to remain open during lunch hour and Fridays
- Immunization staff participates in various outreach events in the community to increase our visibility in the community (MMAC, community health fairs, street market, etc)
-Working with providers at Children's Clinic on staffing for follow-up and reminder calls

c. Plan for the Coming Year

-Procure a bee costume to be used as our mascot
-Expand RPMS (mumps) into all private clinics so that immunization data will be entered into our registry immediately rather than submitted on a monthly log sheet (current process). All immunization information inputted in to RPMS will then be automatically imported in to our immunization registry (WebIZ) via HL-7 interface.
-Procur laboratory quality vaccine storage refrigerators and freezers for all VFC provider clinics in the CNMI in order to get their vaccine storage units up to code. Equipment will arrive by the end of May 2012.
-Open ‘catch-up' clinic at the WIC Clinic. Work with MCH and WIC to track children.

Performance Measure 08: *The rate of birth (per 1,000) for teenagers aged 15 through 17 years.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	30	26.5	26.5	26.5	29
Annual Indicator	21.5	20.3	22.2	37.5	27.1
Numerator	33	32	35	45	29
Denominator	1533	1573	1577	1200	1069
Data Source		live birth certificates	Live Birth Certificates	Birth Certificate Database	Birth Certificate Database
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years					

is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	29	27	27	25	25

Notes - 2011
Source of denominator data is from the US Census Bureau, International Programs, International Data Base. All estimates are based on calendar year.

Notes - 2010
We modified our future objectives as we continue with our work with our partners to decrease the rate of teen births overall. The denominator source is from the 1999 SPC Pop Est. All 2010 and 2011 population data adjusted to estimates based on the current 2010 Census data.

Notes - 2009
35 total teens aged 15-17 years delivered in 2009.

a. Last Year's Accomplishments
-Provided training on family planning counseling to staff at the two other public high schools

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Family planning services provided at the school-based clinic	X		X	
2. Family planning services fees waived for teenagers		X	X	
3. Guests on the Live Teen Talk Show		X	X	
4. Prenatal care provided at the school-based clinic	X		X	X
5. Set up information table during community events		X	X	
6. Conduct presentations as requested		X	X	
7. MCH staff member of the Family Planning Information and Educational materials committee		X	X	X
8. Key staff participated in the Annual Title X Pacific Basin Family Planning Conference	X	X	X	X
9.				
10.				

b. Current Activities
-Preventive services continue to be provided at the school-based clinic and continue to coordinate preventive services with another high school that has a nursing staff
-Continue to conduct outreach activities at community events and health fairs
-Key staff participated in the Annual Title X Pacific Basin Family Planning Conference
-MCH staff a member of the Family Planning Program's Information and Educational Materials committee
-Distributed informational and educational materials during events such as Women's Health Week and Marianas March Against Cancer
-Participated in the HPV Campaign
-Continue with Nursing Assistantship Program promoting leadership and career opportunities
-Conduct presentations at schools when requested
-MCH funds air time for Teen Talk Live addressing topic on pregnancy prevention

c. Plan for the Coming Year
-Submit HRSA Personal Responsibility and Education Program grant application
-Implement grant activities at other schools and organizations if approved

Performance Measure 09: *Percent of third grade children who have received protective sealants on at least one permanent molar tooth.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	60	66	67	79	87.6
Annual Indicator	65.9	90.7	78.5	87.6	90.0
Numerator	1907	691	2099	1943	2114
Denominator	2892	762	2673	2217	2349
Data Source		Dental program	Dental Program	School Dental Program	School Dental Program
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	90	90	90	92	92

Notes - 2011
Please note that these are students enrolled in 1st, 5th, and 6 grades. For school year 2010-2011 only public elementary school students participated in the program. Head Start also participated but is not include in the reporting.

Notes - 2010
Please note that these are students enrolled in 1st, 5th, and 6 grades. For school year 2010-2011 only public elementary school students participated in the program. Head Start also participated but is not include in the reporting.

Notes - 2009
Of the 2,673 (1st, 5th, and 6th grade) enrollees, 2,099 received protective sealant in 2009. 1st graders data is pending and will be subsequent data submission.

a. Last Year's Accomplishments
-Received sealants from Oral Health America
-Conducted fluoride varnish application at WIC Clinic and Immunization Clinic
-Provided sealant application to children referred from WIC and Immunization Clinic

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Collaborate with Public School System for transportation to PH Dental Clinic	X	X	X	X
2. Purchase fluoride varnish and sealants		X	X	
3. Continue with partnership with Oral Health America		X	X	X
4. Awareness campaing on Oral Health - including prenatal care		X	X	
5. Continue to provide incentives during school program		X	X	
6. Conduct oral health training that includes staff from Immunization, WIC, Home Visiting and Head Start Program	X	X	X	X
7. Participate in community events that include providing fluoride varnish application		X	X	
8. Partner with WIC and Immunization Programs to provide sealant and fluoride varnish application	X	X	X	X
9.				
10.				

b. Current Activities

1) Primary Oral Health Training conducted to staff at Dental Clinic, Home Visiting, Immunization, and nurses
2) Continue School Dental Program that provide sealant and fluoride varnish applications to students
3) Refer to private dental clinics for restorative care, especially the Medicaid participants
4) Procure supplies and brochures for the program
5) Continue with our partnership with Oral Health America
6) Conduct outreach activities during community events and health fairs
7) Continue with incentive program in collaboration with ECCS
8)Conduct Awareness Campaign
9)Submit HRSA grant to support states oral health workforce activities

c. Plan for the Coming Year

-Oral health a component to families in the Home Visiting Program
-Implement OH grant activities once approved

Performance Measure 10: *The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective	6	0	10	10	0
Annual Indicator	0.0	6.1	6.2	0.0	0.0
Numerator	0	1	1	0	0
Denominator	16443	16372	16244	13946	13555
Data Source		Death certificates	Death certificates	Death certificates	Death certificates
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and			Yes	Yes	Yes

2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	0	0	0	0	0

Notes - 2011
There was no child death caused by motor vehicle crashes in 2011. Denominator source data is from the US Census Bureau, International Programs, International Data Base. All estimates are based on calendar year.

Notes - 2010
There was no child death caused by motor vehicle crashes in 2010. A 3 year moving average would still be less than 5. Denominator source is from the 1999 SPC Pop Est. All 2010 and 2011 population data adjusted to estimates based on the current 2010 Census data.

Notes - 2009
Only 1 motor vehicle fatality in 2009 for 14 yrs and below.

a. Last Year's Accomplishments
Conducted Annual Health and Safety training with exhibits on child safety including car seats and seat belts

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Conducted annual Health and Safety training that includes exhibits from various partners to day care center providers		X	X	X
2. A partner in the Week of the Young Child awareness event		X	X	
3. Continue to provide referrals to Office of Highway Safety		X	X	
4. Procured brochures on car seats for Nursery Unit		X	X	
5. Continue with collaboration with the Head Start Program Community Partners, ECCS and Childcare Program on child safety awareness		X	X	
6. Provide brochures on injury prevention to Head Start and day care centers		X	X	
7.				
8.				
9.				
10.				

b. Current Activities
-Continue with procuring of brochures provided to parents that includes drinking and driving
-Continue with collaboration with the Head Start Program Community Partners, ECCS and Childcare Program on child safety awareness
-As an advisory member of Project Brabu in which underage drinking is a priority focused area, the MCH Program will be working with subgrantees such as DARE Program to work on activities for this focused area.
-Continue to be participate in the "Week of the Young Child" awareness event

-Provide brochures on injury prevention to Head Start and day care centers

c. Plan for the Coming Year
MCH will support to subgrantees in the implementation of activities under the Community Guidance Center Project Brabu in which the Program Coordinator serves on the governor's advisory council.

Performance Measure 11: *The percent of mothers who breastfeed their infants at 6 months of age.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	80	80	33	37	25.5
Annual Indicator	35.0	19.4	36.9	25.1	51.6
Numerator	485	245	527	252	464
Denominator	1385	1266	1427	1003	899
Data Source		WIC program	WIC program	WIC program	WIC Program
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	52	52	53	53	54

Notes - 2011
The data is only WIC participants. There were 899 mothers with 6 month old babies enrolled in WIC in 2011.

Notes - 2010
The data is only WIC participants. There were 1003 mothers with 6 month old babies enrolled in WIC.

Notes - 2009
In 2009, 1,427 number of mothers served under WIC program and 527 infants were breastfed at 6 months of age. 154 never breastfed. The implementation of the WIC Program data system has allowed for the program to provided more accurate counts and also the establishment of the clinic for 2 years now has enabled partners to refer to the WIC Program thus the increase in the numerator.

a. Last Year's Accomplishments
-The free prenatal classes, called Triple Treat conducted at the WIC clinic for anyone interested not limited to WIC participants. Topics include pregnancy, delivery and postpartum. Breastfeeding benefits, making plenty of milk, understanding how milk is made, proper latching and positioning are being discussed in these classes.
-Hospital visits to postpartum moms were being done daily by Breastfeeding Services Counselor

(BSC) to provide support, counseling, education to moms who are having difficulty nursing or have any concerns about breastmilk or breastfeeding.
-Breastfeeding referrals to BSC for counseling and support. Breastpump loaner program established.
-Recruitment of a Chinese translator 4 days a week 4 hours a day.
-First Food Day event was held on October 24, 2011. This provided WIC Program with the venue to increase awareness on healthy, affordable food.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Conduct Triple Treat Classes that includes breastfeeding		X	X	X
2. Make referrals to WIC Program for breastfeeding counseling		X	X	
3. Working on design of a nurture blanket with nursery nurses and WIC staff		X	X	
4. Working with WIC and Hospital Director on reinstating and reinforcing CHC breastfeeding policiy		X	X	X
5. Clinic bulletin board show case every month nutrition education messages and breastfeeding.		X	X	
6. WIC clinic staff continue with online continuing education on nutrition education and breastfeeding developed by Arizona Department of Health		X	X	X
7. Support breastfeeding at the hospital (CHC) - prenatal class, training, education awareness, written resources		X	X	
8.				
9.				
10.				

b. Current Activities
-Clinic bulletin board show case every month nutrition education messages and breastfeeding.
-Clinic staff is doing online continuing education on nutrition education and breastfeeding developed by Arizona Department of Health for their staff who work at WIC.
-Support breastfeeding at the hospital (CHC), WIC donated 20 hospital grade breastpumps and some kits for the Breastpump loan program.
-Conduct in-service on how to use and maintain the breastpumps
-Hired 3 Breastfeeding Peer Counselors
-Procured and use the magazines from the National WIC Association that were developed for our participants
-Recruit WIC Clinic Manger
-Procured and use the breastfeeding "Keep it Simple" book for parent education activities
-Referral to WIC Program

c. Plan for the Coming Year
-Build capacity by hiring more key Clinic staff: Nutritionist (Registered Dietitian) and Nutrition Assistants.
-Breastfeeding Peer Counselors to start conducting breastfeeding basic classes in December 2012 and to continue providing support and encouragement to WIC mothers at the hospital and in the WIC clinic.
-Breastfeeding Peer Counselors to attend NWA Nutrition and Breastfeeding Conference in September 2012.
-Will celebrate Food Day again on October 24, 2012.

-Work with MCH and Hospital to enforce breastfeeding policy

Performance Measure 12: *Percentage of newborns who have been screened for hearing before hospital discharge.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	100	99	99	99	98
Annual Indicator	97.7	98.3	98.7	97.9	98.1
Numerator	1353	1244	1096	1049	1013
Denominator	1385	1266	1110	1072	1033
Data Source		EHDI	EHDI	EHDI Surveillance System	EHDI Surveillance System
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Final
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	98.5	98.5	98.5	99	99

Notes - 2011
The babies that were not screened had other immediate medical needs, were sent off-island for care, or born to tourist mothers.

Notes - 2010
The 26 babies that were not screened were either because parents refused (a waiver form was signed) or they had other urgent medical needs. In 2009 CDC data showed that over 97% of newborns were screened for hearing loss in the U.S. Please note that we have reduced our percent on loss to follow up from 15.63% in 2009 to 5.33% in 2010.

Notes - 2009
In 2009, 1096 of newborn had hearing screening before hospital discharge. Early Hearing Detection and Intervention surveillance system provided us with the data.

a. Last Year's Accomplishments
- Screened 98% of infants before hospital discharge
- Implement electronic quarterly newsletter for providers
- Showcased our "Lost to Follow-Up" efforts at the Poster Session at last year's EHDI conference
- CNMI submitted pictures of our children and one was selected to be included in NCHAM's Communicate with you Child booklet
- Audiological Diagnostics Evaluations done as early as 24 days

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**

	DHC	ES	PBS	IB
1. Continue with our media awareness campaign. Continue referral to EIS		X	X	
2. Provide annual training such as Listening and Spoken Language for early interventionist	X	X	X	X
3. Conduct family events including the 6th annual Family Support event that includes hosting the event on the islands of Rota and Tinian		X	X	
4. Key staff attended the annual EHDI conference			X	
5. Stickers are placed in child's medical record to alert physician if child has not been tested or needs rescreening		X	X	
6. Provide parents with 'hearing track cards' so they Continue with gas voucher incentives				
7. Dr. Christine Crank, pediatrician has volunteered to be the EHDI champion	X	X	X	X
8. Working with the Vital Statistics Office as they update their data collection to the 2003 birth certificate standard (EHDI database is directly linked with this system)			X	X
9.				
10.				

b. Current Activities

-. Continue with our media awareness campaign
- Provide annual training such as Listening and Spoken Language for early interventionist
- Conduct family events including the 6th annual Family Support event that includes hosting the event on the islands of Rota and Tinian
- Key staff attended the annual EHDI conference
-Stickers are placed in child's medical record to alert physician if child has not been tested or needs rescreening
-Provide parents with 'hearing track cards' so they Continue with gas voucher incentives
-can monitor child's development
-Dr. Christine Crank, pediatrician, has volunteered to be the EHDI champion
-Continue partnership with Early Intervention Services Program

An attachment is included in this section. IVC_NPM12_Current Activities

c. Plan for the Coming Year

-Build capacity to collect the Primary Care Physicians (PCP) within the present EHDI-IS with a specific focus to use this data element to reduce loss to follow-up services.
-Build capacity to exchange information with the CNMI WIC program to reduce the number of infant's loss to follow up.
-In collaboration with the Vital Statistics Office the EHDI program will explore the capacity to collect cell phone numbers from families to send out speech and language developmental milestones and reminder follow up appointments for infants identified with high risks for late onset hearing loss via text messaging / email.
-All infants (100%) receive newborn hearing by 1 month of age.

Performance Measure 13: *Percent of children without health insurance.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective	44	43	60	60	80

Annual Indicator	50.7	61.7	61.0	80.0	68.4
Numerator	9961	12155	12000	12894	10959
Denominator	19636	19707	19657	16115	16024
Data Source		RPMS	RPMS	RPMS	RPMS
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Final
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	68.4	68.4	68.4	68	68

Notes - 2011
Source of denominator data is from the US Census Bureau, International Programs, International Data Base. All estimates are based on calendar year.

Notes - 2010
Data is collected through the RPMS and denominator source is the 1999 SPC Pop Est. All 2010 and 2011 population data adjusted to estimates based on the current 2010 Census data.

Notes - 2009
12000 children without health insurance including 101 visitors derived from RPMS.

a. Last Year's Accomplishments
-Provided information to partner programs to assist with eligibility assistance
-Provided application packages to partner programs

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Include Medicaid Program information on all MCH ads		X	X	
2. Continue to provide eligibility assistance		X	X	
3. Continue to work with Finance Unit and Medical Records to improve reporting of health insurance		X	X	
4. Continue with referrals to Medicaid Program and Medically Indigent Assistance Program; including referrals directly from health care providers (please note that referrals from public health facilities or health care providers are given first prioriti		X	X	
5. Provide transportation and translation as requested		X	X	
6.				
7.				
8.				
9.				
10.				

b. Current Activities
-Include Medicaid Program information on all MCH ads
- Continue to provide eligibility assistance
- Continue to work with Finance Unit and Medical Records to improve reporting of health insurance
- Continue with referrals to Medicaid Program and Medically Indigent Assistance Program;

including referrals directly from health care providers (please note that referrals from public health facilities or health care providers are given first priorities to be processed)
- Provide transportation and translation as requested

c. Plan for the Coming Year
-Continue to work with our community partners such as Head Start Program to enroll children and families into the Medicaid Program including processing of applications especially for children with special health care needs
-Train Home Visiting Program staff on eligibility assistance
-Work with Kagman Community Health Center on eligibility assistance for their clients

Performance Measure 14: *Percentage of children, ages 2 to 5 years, receiving WIC services with a Body Mass Index (BMI) at or above the 85th percentile.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	50	50	30	35	22
Annual Indicator	0.0	25.9	34.8	22.6	23.3
Numerator	1	308	984	1041	1084
Denominator	5220	1188	2824	4602	4645
Data Source		WIC program	WIC program	WIC Program	WIC Program
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	23	23	23	22	22

Notes - 2011
The WIC Program has been a key partner in our work to decreasing childhood obesity. The increase in WIC participants is attributed to reduction of working hours, unemployment, high cost of utility and fuel, etc.

Notes - 2010
The WIC Program has been a key partner in our work to decreasing childhood obesity. The increase in WIC participants is attributed to reduction of working hours, unemployment, high cost of utility and fuel, etc. Please note that we modified our future objectives as we want to reduce our percentage of children, ages 2 to 5 years, with a BMI at or above the 85th percentile (WIC Program clients)

Notes - 2009
There were 2,824 total children under WIC program. A total of 984 children at or above the 85%ile BMI and 2,270 children below the 85%ile BMI.

a. Last Year's Accomplishments

- Recruitment of staff that can translate to chinese
Staff training on understanding baby behavior to determine the difference between infant hunger cues and non-hunger cues.
-EveryMother also trained key Clinic staff on "Using Loving Support to Implement Best Practices in Peer Counseling.™" So that we could be ready to implement a peer counseling program in the CNMI.
-Completed the post new food package implementation survey for fruit and vegetable consumption in the CNMI or NATFAN survey by Texas A&M.
-Conducted focus groups to create and test nutrition education materials specific to the needs of the CNMI population. 4 very tailored handouts were developed and translated into Chinese.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. New information is posted on clinic bulletin board every month with a focus on nutrition education messages and breastfeeding.		X	X	
2. Recruit WIC Clinic Manger	X	X	X	X
3. Do further capacity building on our Participant Centered Services Skills	X	X	X	X
4. WIC Clinic staff doing online continuing education on nutrition education and breastfeeding	X	X	X	X
5. Establish and implement the Peer Counseling Program to provide direct support and counseling to WIC mothers.		X	X	X
6.				
7.				
8.				
9.				
10.				

b. Current Activities
-Continue with posting new information on clinic bulletin board every month with a focus on nutrition education messages and breastfeeding.
-Recruit WIC Clinic Manger
- Continue with capacity building on our Participant Centered Services Skills,
-WIC Clinic staff doing online continuing education on nutrition education and breastfeeding
-Establish and implement the Peer Counseling Program to provide direct support and counseling to WIC mothers.

c. Plan for the Coming Year
-Hire more key Clinic staff: Clinic Manager, Nutritionist (Registered Dietitian), Nutrition Technician and Nutrition Assistant.
-Procure written materials in nutrition education and breastfeeding with creative messages

Performance Measure 15: *Percentage of women who smoke in the last three months of pregnancy.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**

Annual Performance Objective	1	60	20	5	1
Annual Indicator	100.0	6.1	5.0	1.1	1.4
Numerator	1	76	55	12	14
Denominator	1	1255	1107	1072	1033
Data Source		Birth Certificates	Birth Certificates	Birth Certificates	Chart Review
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	1.4	1.4	1.4	1	1

Notes - 2011
Again, this information is not being completed on the birth certificate forms. We are working with Mgr of Vital Statistics Office and Nursing Director on making sure that this information is completed. We conducted a 106 chart reviews of mothers that gave birth last year and found 14 said yes to tobacco. However, it was not documented whether this was smoking or chewing. Betel nut chewing with tobacco is practice here in the CNMI.

Notes - 2010
We continue to bring referral cards to the Tobacco Program in addition to the Quitline Number to our patients. This is also provided at the private health clinics. We are currently gathering this data from the Labor and Delivery Unit in addition to chewing betel nut with tobacco.

Notes - 2009
In 2009 birth certificate registration, women were generally asked if they use tabacco or smoking during their pregnancy. 2010 revision questions were more detailed about smoking during 1st, 2nd, and 3rd trimesters.
55 pregnant women used tabacco/smoking during their pregnancy in 2009.

a. Last Year's Accomplishments
-Included this information on the 2003 birth certificate standard form

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Participated in the Kick Butts Day and World No Tobacco Day events		X	X	
2. Education and counseling provided at prenatal care visits		X	X	
3. Continue work to make sure that information is recorded on the birth certificate		X	X	X
4. Continue with referral to cessation program		X	X	
5. Continue with prenatal care ads that include information on the effects of smoking		X	X	
6. 7) MCH Program a member of NCD task force in which providing information/program to our community to stop smoking				

is one of the focused areas.				
7. Conducted chart reviews in which information on smoking was one of the criteria reviewed		X	X	X
8. Participated in Health Pocket Meetings which are held at homes of key leaders in the villages on NCDs		X	X	
9.				
10.				

b. Current Activities

- Participated in the Kick Butts Day and World No Tobacco Day events
- Education and counseling provided at prenatal care visits
-Continue work to make sure that information is recorded on the birth certificate
-Continue with referral to cessation program
-Continue with prenatal care ads that include information on the effects of smoking
-Continue to provide women the Prenatal Health Book with pregnancy and tobacco information
-MCH Program a member of NCD task force in which providing information/program to our community to stop smoking is one of the focused areas.
-Continue to refer to smoking cessation classes
-Conducted chart reviews in which information on smoking was one of the criteria reviewed
- Participated in Health Pocket Meetings which are held at homes of key leaders in the villages on NCDs
- Procure tablets for nurses to fill out revised birth certificate forms electronically

c. Plan for the Coming Year

-As a member of the NCD task force, the Program will work with its partners on the activities on the NCD strategic plan for the CNMI.
-Color code birth certificate forms to ensure the required information is completed -- i.e. all yellow colors are to be filled by nurses and blue by mother

Performance Measure 16: *The rate (per 100,000) of suicide deaths among youths aged 15 through 19.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	5	1	20	0	0
Annual Indicator	0.0	18.9	0.0	0.0	0.0
Numerator	0	1	0	0	0
Denominator	4762	5279	5470	4608	4308
Data Source		Death certificates	Death certificates	Death certificates	Death Certificates
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.			Yes	Yes	Yes
Is the Data Provisional or Final?				Final	Final

	2012	2013	2014	2015	2016
Annual Performance Objective	0	0	0	0	0

Notes - 2011
There were no suicide deaths this year among youths aged 15 through 19. Denominator data source is US Census Bureau, International Programs, International Data Base. All estimates are based on calendar year.

Notes - 2010
There is no suicide deaths among youths aged 15 through 19 for the past 2 years. The 3 year moving average is still fewer than 5 events. Please note that we want our objective to be 0 for future years.

Source of all denominator data is from the US Census Bureau, International Programs, International Data Base. All estimates are based on calendar year 2011.

Notes - 2009
No suicide fatality for teens 15-19 yrs of age in 2009.

a. Last Year's Accomplishments
-MCH Program Coordinator attended the Applied Suicide Intervention Skills Training (ASIST)
-Nursing Assistantship Program implemented

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continue to make counseling available and accessible to teens	X	X	X	
2. Continue to work with our partners to in events focusing on teen		X	X	
3. Written materials and web-sites addressing teen issues including suicide are provided at the school-based clinic		X	X	
4. MCH funds air time for Teen Talk Live that addresses teen issues such as suicide		X	X	
5. Teen Truth Live came to CNMI – motivational speakers presented on issues that students face but don't talk about (included films that students produced on different topics)		X	X	
6. Teen Talk Facilitator and Teen Talk members evaluates activities for MCH program		X	X	X
7.				
8.				
9.				
10.				

b. Current Activities
-Continue to make counseling available and accessible to teens
-Continue to work with our partners to in events focusing on teen
-Written materials and web-sites addressing teen issues including suicide are provided at the school-based clinic
-MCH supports Community Guidance Center's training on suicide counseling
-MCH funds air time for Teen Talk Live that addresses teen issues such as suicide
-Teen Truth Live came to CNMI -- motivational speakers presented on issues that students face but don't talk about (included films that students produced on different topics)

-Teen Talk Facilitator and Teen Talk members evaluates activities for the MCH program

c. Plan for the Coming Year
-Submit Personal Responsibility and Education Program grant application
-Implement grant work plan if approved
-Collaborate with community programs addressing adolescent leadership

Performance Measure 17: *Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	1	1	1	1	1
Annual Indicator	100.0	100.0			
Numerator	1	1			
Denominator	1	1			
Data Source		No high risk facility	No high risk facility	Exempted from reporting	Exempted from reporting
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	1	1	1	1	1

Notes - 2011
The CNMI is exempted from reporting on this performance measure as we are not a high-risk facility.

Notes - 2010
The CNMI is exempted from reporting on this performance measure as we are not a high-risk facility.

Notes - 2009
CNMI is excluded from this performance measure due to no high risk facility on island.

a. Last Year's Accomplishments
CNMI is excluded from reporting on the performance measure. The hospital is not a high risk facility.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**

1. CNMI is excluded from reporting on the performance measure. The hospital is not a high risk facility.				X
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
CNMI is excluded from reporting on the performance measure. The hospital is not a high risk facility.

c. Plan for the Coming Year
CNMI is excluded from reporting on the performance measure. The hospital is not a high risk facility.

Performance Measure 18: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	29	29.9	30	30.9	29.5
Annual Indicator	29.1	17.2	28.2	29.4	25.8
Numerator	403	219	316	315	266
Denominator	1385	1272	1119	1072	1033
Data Source		Birth registration	Birth registration	Birth registration	Labor and Delivery Records
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	25.8	25.8	27	27	27.5

Notes - 2011
There are 185 missing records in the birth certificate database. We will be pulling medical records to get data on when they came in for first prenatal visits and insurance status.

Notes - 2010

Although Medicaid is accepted at 4 private health clinics that provide prenatal care services, transportation continues to be a barrier for our community. Per postpartum survey results, women would come for prenatal if they had transportation. We have plans to conduct prenatal care at 4 villages on Saipan.

Notes - 2009
There were 316 pregnant women received prenatal care in the first trimester.

a. Last Year's Accomplishments
-Conducted the Perinatal Continuing Education Program (PCEP)
-Purchase equipment for loan

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continue to offer the free prenatal care classes in partnership with WIC and Hospital Division		X	X	X
2. Continue with prenatal media campaign that includes Medicaid Program information and Medicaid participating private clinics.		X	X	
3. In celebration of National Women's Health Week we include a schedule of prenatal care visits		X	X	
4. Mid-level providers are stationed at Women's Clinic thus a provider is always available	X	X	X	X
5. Prenatal brochures provided to Medicaid Office, Child Care Program, Head Start Program, and EIS Program		X	X	
6. WIC Program refer for prenatal care service	X	X	X	
7. Primary Oral Health training topics included Oral Health in Pregnancy and Oral Health Education and Ultrasonic scaling for diabetic patients and pregnant mothers	X	X	X	X
8.				
9.				
10.				

b. Current Activities
-Continue to offer the free Triple Treat prenatal care classes in partnership with WIC and Hospital Division (Attach is the prenatal information record used in the classes - this was adapted from the Prenatal booklet we developed 5 years ago)
-Continue with prenatal media campaign that includes Medicaid Program information and Medicaid participating private clinics.
-In celebration of National Women's Health Week we include a schedule of prenatal care visits
- Mid-level providers are stationed at Women's Clinic thus a provider is always available
-Prenatal brochures provided to Medicaid Office, Child Care Program, Head Start Program, and EIS Program
-Procure tablets for nurses to fill out revised birth certificate forms electronically
-WIC Program refer for prenatal care service
-Primary Oral Health training topics included Oral Health in Pregnancy and Oral Health Education and Ultrasonic scaling for diabetic patients and pregnant mothers
-Working with Women's Clinic providers on staffing for follow-up and reminder calls
An attachment is included in this section. IVC_NPM18_Current Activities

c. Plan for the Coming Year

-Recruitment of providers
-Provide prenatal service at the Federally Qualified Health Center -- the Kagman Community Health Center
-Implement oral health grant activities at the Women's Clinic if approved
-Color code birth certificate forms to ensure the required information is completed -- i.e. all yellow colors are to be filled by nurses and blue by mother

D. State Performance Measures

State Performance Measure 1: *The percent of mothers who breastfeed their infants at hospital discharge.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective					64
Annual Indicator				64.4	39.0
Numerator				690	403
Denominator				1072	1033
Data Source				Birth Records	Discharge Records
Is the Data Provisional or Final?				Provisional	Provisional
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	65	66	67	68	68

Notes - 2011
This data is from the Labor and Delivery Unit logbooks. We are working with Labor and Delivery, Nursery, and Health and Vital Statistics new Electronic Birth Record systems to collect more accurate data for this state priority.

Notes - 2010
This data is from the birth certificate. We are working with Labor and Delivery and Nursery to collect more accurate data for this state priority.

a. Last Year's Accomplishments
Implement Prenatal Care Classes; enroll pregnant women in classes

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Implement Prenatal Care Classes; enroll pregnant women into class		X	X	
2. Include breastfeeding information in the prenatal care packet; include breastfeeding information in awareness campaigns		X	X	
3. Refer pregnant women to WIC Program		X	X	
4. Provide education to mothers at maternity ward; Reinforce counseling during postpartum visits		X	X	
5. Work with Hospital Division and WIC Program to reinforce breastfeeding policy at the Commonwealth Health Center	X	X	X	X
6. Procure educational materials include DVDs		X	X	

7. Continue to support training to nursing/clinical staff that includes breastfeeding		X	X	X
8. Meet with Nursing Director and pedicatricians on how to best capture data		X	X	X
9.				
10.				

b. Current Activities
-Include breastfeeding information in the prenatal care packet
-Refer pregnant women to WIC Program
-Provide education to mothers at maternity ward
-Reinforce counseling during postpartum visits
-Conduct awareness campaigns; procure educational materials include DVDs
-Work with Hospital Division and WIC Program to reinforce breastfeeding policy at the Commonwealth Health Center
-Continue with training to nursing staff that includes breastfeeding
-Meet with Nursing Director and pediatricians on how to best capture data
-Working with WIC Program on design for 'nurture blanket'

c. Plan for the Coming Year
-Work with WIC Breastfeeding Peer Counselors
-Provide support for breastfeeding education and counseling at FQHC - Kagman Community Health Center

State Performance Measure 2: *Percent of pregnant women enrolled in the Medicaid Program receiving prenatal care beginning in the first trimester.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective					30
Annual Indicator				28.6	20.0
Numerator				103	72
Denominator				360	360
Data Source				Birth Registration	Chart Review
Is the Data Provisional or Final?				Provisional	Provisional
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	30	30	30	30	30

Notes - 2011
According to the logbook from the women's clinic there were 40 women enrolled in Medicaid Program receiving prenatal care beginning in the first trimester at CHCC. Please note that there are 4 othere private clinics on Saipan performing prenatal services. Also note that we were not able to get the denominator before the due data from the Medicaid Program, so we will use last year's number.Chart review conducted after data submission.

Notes - 2010
This is our first year to report on this state priority. The denominator (360)relfects the total number of pregnant women enrolled int he Medicaid Program that receive prenatal care. Of these 103 received prental care beginning in the first trimester.

a. Last Year's Accomplishments

-Conduct Perinatal Continuing Education Program

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Partner with WIC Program to assist women to enroll in the Medicaid Program		X	X	X
2. Refer pregnant women to Medicaid Program		X	X	
3. Conduct Perinatal Continuing Education Program	X	X	X	X
4. Continue with media campaign on prenatal care; Include Medicaid Program information on all media campaign		X	X	
5. Partner with Medicaid participating private clinics for reporting		X	X	X
6. MCH program provide eligibility assistance		X	X	
7. Refer to Home Visiting Program for tracking		X	X	
8. Provide staffing assistance to Women's Clinic for follow-up and reminder calls		X	X	X
9. Provide pregnancy test kits at public health centers		X	X	
10.				

b. Current Activities
-Partner with WIC Program to assist women to enroll in the Medicaid Program
-Refer pregnant women to Medicaid Program
-Include Medicaid Program information on all media campaign
-Continue with media campaign on prenatal care
-Partner with Medicaid participating private clinics for reporting
-MCH program provide eligibility assistance
-Provide pregnancy test kits at public health centers

c. Plan for the Coming Year
-Refer to Home Visiting Program for tracking
-Provide staffing assistance to Women's Clinic for follow-up and reminder calls
-Support prenatal service at FQHC -- Kagman Community Health Center

State Performance Measure 3: *Provision of case management of pregnant women identified as "high risk"*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective					1
Annual Indicator				12	16
Numerator				12	16
Denominator				1	1
Data Source				MCH Program	Women's Clin
Is the Data Provisional or Final?					Provisional
	2012	2013	2014	2015	2016
Annual Performance Objective	1	1	1	1	1

Notes - 2011
There were 49 women that were either diabetics or developed gestational diabetes and 9 women with elevated BP last year. Please note that there is only 1 OB/GYN now at the Women's Clinic. With the departure of Dr. Grant no supplies (strips) were ordered and I met with the nurse to inform her to let me know and MCH will procure the needed supplies.

Notes - 2010
This performance measure is based on scale rating (see attached)

a. Last Year's Accomplishments
-Designation of 1 mid-level provider for case management
-Procurement of equipment for loaner program
-Policy in place, loaner equipment implemented,

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Develop/review policy for case management of high risks pregnancies		X	X	X
2. Refer pregnant women to WIC Program including nutrition counseling		X	X	
3. Implement loaner program (i.e. accuchek machine and strips)		X	X	
4. Procure supplies as needed for loaner program		X	X	
5. Provide training such as Perinatal Continuing Education Program	X	X	X	X
6. Provide pregnancy kits at public health centers		X	X	
7. Provide staffing support for follow-up and reminder calls		X	X	
8. Work with FQHC – Kagman Community Health Center – on case management and referrals	X	X	X	X
9.				
10.				

b. Current Activities
-Refer pregnant women to WIC Program including nutrition counseling
-Develop/review policy for case management of high risks pregnancies
-Procure supplies as needed for loaner program
-Provide training such as Perinatal Continuing Education Program
-Provide pregnancy kits at public health centers
-Provide pregnancy test kits at public health centers

An attachment is included in this section. IVD_SPM3_Current Activities

c. Plan for the Coming Year
Work with FQHC -- Kagman Community Health Center -- on case management and referrals

State Performance Measure 8: *The rate of birth (per 1,000) for Chamorro teenagers aged 15 through 18 years.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance	2007	2008	2009	2010	2011

Data					
Annual Performance Objective					29
Annual Indicator				29.1	27.2
Numerator				45	42
Denominator				1544	1544
Data Source				Birth Certificate	Birth Records
Is the Data Provisional or Final?				Final	Final
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	29	27	25	25	25

Notes - 2011
Due to unavailability of 2010 US Census Report denominator data source is 1999 SPC Pop Estimate. Per the 2011 YRBS, Among high school students who had sexual intercourse during the past 3 months, the percentage who used birth control pills to prevent pregnancy before last sexual intercourse remained the same 13.9 in 2009 and 13.9 in 2011. Denominator: Pending release of 2010 Census Data with ethnic breakdown of population.

Notes - 2010
There were 45 teen births aged 15-18 years. Per 1999 SPC Pop Est there are 1,544 teens aged 15-18 years in the CNMI.

a. Last Year's Accomplishments
The partnership of Teen Talk group

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	**ES**	**PBS**	**IB**
1. Conduct focus group with chamorro teens and parents to provide guidance on strategies that would help our work reduce teen births		X	X	
2. Provide data to Teen Talk group to increase awareness of teen birth rate in the CNMI especially for targeted group		X	X	
3. Continue to work with school to implement programs such as the Nurse Assistantship Program		X	X	X
4. Work with Youth Congress on policies and funding for programs		X	X	X
5. Looking for funding opportunity announcements with a focus on pregnancy prevention	X	X	X	X
6. Provide support, including training, for program facilitators		X	X	X
7. Continue to provide preventive services at school-based clinic	X	X	X	X
8. MCH fund for air time for Teen Talk Live Show		X	X	
9.				
10.				

b. Current Activities
-Provide data to Teen Talk group to increase awareness of teen birth rate in the CNMI especially for targeted group
-Continue to work with school to implement programs such as the Nurse Assistantship Program
-Work with Youth Congress on policies and funding for programs
-Looking for funding opportunity announcements with a focus on pregnancy prevention
-MCH funds air time for Teen Talk Live that addresses teen issues such as suicide
-Teen Talk Facilitator and Teen Talk members evaluates activities for the MCH program

-Provide support, including training, for teen group program facilitators

c. Plan for the Coming Year
-Conduct focus group with chamorro teens and parents to provide guidance on strategies that would help our work reduce teen births
-Submit HRSA Personal Responsibility and Education Program grant application

State Performance Measure 9: *Percentage of high school students who ever had a drink of alcohol, other than a few sips*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective					15
Annual Indicator			0.2	0.2	50.4
Numerator			12	12	2569
Denominator			6229	6229	5093
Data Source			MCH Program	MCH Progam	PSS - YRBS
Is the Data Provisional or Final?				Provisional	Provisional
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	50.4	50	50	50	50

Notes - 2011
Per the 2011 YRBS, the Percentage of high school students who had at least one drink of alcohol on one or more of the past 30 days 38.8 in 2009; 41.4 in 2011. The data for this SPM is from YRBS as recommended by partners.

Notes - 2010
Although we have conducted activities for this priority need, we will do a scale rating to measure it. For now we are reporting the number of presentations we have conducted at the high school level.

a. Last Year's Accomplishments
The YRBS was conducted in 2011 by Public School System. MCH is able to obtain survey results in a timely manner.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. MCH funds air time for Teen Talk Live that addresses teen issues such as suicide		X	X	
2. Teen Talk Facilitator and Teen Talk members evaluates activities for the MCH program		X	X	X
3. Provide support to conduct YRBS		X	X	X
4. Support Project Brabu's subgrantees proposals/programs addressing underage drinking		X	X	
5. Provide support, including training, for teen group program facilitators		X	X	X

6. Work with schools to implement programs such as Nurse Assistantship Program		X	X	X
7. Integrate other components to connect other segments of the community (e.g., parents) to strategies		X	X	
8. Work with teen groups to develop messages that is acceptable among youths		X	X	
9. Support and participate in 'sting' operation activity		X	X	
10. Submit HRSA Personal Responsibility and Education Program grant application	X	X	X	X

b. Current Activities

-MCH funds air time for Teen Talk Live - topics include drinking/binging, sexual activity, life building skills, etc.
-Teen Talk Facilitator and Teen Talk members evaluates activities for the MCH program
-Provide support to conduct YRBS
-Support Project Brabu's subgrantees proposals/programs addressing underage drinking
-Provide support, including training, for teen group program facilitators
-Work with schools to implement programs such as Nurse Assistantship Program
-Integrate other components to connect other segments of the community (e.g., parents) to strategies
-Work with teen groups to develop messages that is acceptable among youths
-Support and participate in 'sting' operation activity

c. Plan for the Coming Year

-Submit HRSA Personal Responsibility and Education Program grant application
-Implement workplan once grant application is approved

State Performance Measure 10: *Input information on infants with a diagnosis at birth into the Birth Defects Registry within 6 months.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective					3
Annual Indicator			2.5	2.5	2.5
Numerator			27	27	26
Denominator			1072	1072	1033
Data Source			Birth Defects Database	Birth Defects Database	Birth Defects Database
Is the Data Provisional or Final?				Provisional	Provisional
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	1.2	1.5	2	2.5	3

Notes - 2011

The low number is because this information is not being completely filled out in the birth certificate form. MCH is providing staffing support to ensure completion of information. Also, birth certificate forms will be color coded so that individuals responsible to fill out information will know

which ones to complete. Numerator updated; data source is Early Intervention Services due to incomplete data in Birth Certificates.

Notes - 2010
These are the numbers of birth certificates that has information on anamolies filled out. We are working with providers to ensure that information are filled out completely and accurately on the birth certificates. There were 48 referrals to early intervention services last year. Please note that this is the first time we are reporting on this state priority.

a. Last Year's Accomplishments
The development of the Birth Defects Registry Database.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Generate information from Birth Certificate Form; Cross check information with Birth certificate database		X	X	X
2. Input information into Birth Defects Registry		X	X	X
3. Provide staffing support to Vital Statistics Office to ensure information completed on birth certificate form and STEVE		X	X	X
4. Support training for CSHCN/EIS providers			X	X
5. Make referrals to EIS	X		X	
6. Provide EIS information to providers; Sent letter to provider with an update on each child referred for earrly intervention services		X	X	
7.				
8.				
9.				
10.				

b. Current Activities
-Generate information from Birth Certificate Form; Cross check information with Birth certificate database
-Input information into Birth Defects Registry
-Provide staffing support to Vital Statistics Office to ensure information completed on birth certificate form and STEVE
-Support training for CSHCN/EIS providers
-Make referrals to EIS
-Provide EIS information to providers; Sent letter to providers with an update on each child they referred for early intervention services

c. Plan for the Coming Year
Procure tablets for nursing staff to enter data electronically instead of writing into logbooks

State Performance Measure 11: *Percent of children aged 6 months to 5 years that receive fluoride varnish application at the Children's Clinic*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011

Annual Performance Objective					
Annual Indicator					15.9
Numerator					739
Denominator					4645
Data Source					Dental Clinic; WIC Program
Is the Data Provisional or Final?					Provisional
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	15.9	16	16	17	17

Notes - 2011
Please note that these were the number of children we saw at the WIC Clinic last summer (2 month period). We will be tracking the numbers with Children's Clinic for reporting next year. The numerator was provided by the Dental Clinic and denominator was provided by WIC Program. These are children we saw age 2 to 5.

a. Last Year's Accomplishments
Dental Clinic staff provided fluoride varnish application at the WIC Clinic for two months last summer.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Develop database for tracking		X	X	X
2. Provide oral health brochures to parents		X	X	
3. Procure fluoride varnish application kits and associated supplies		X	X	
4. Continue partnership with Oral Health America for fluoride varnish application kits	X	X	X	X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
Develop database for tracking
Provide oral health brochures to parents
Procure fluoride varnish application kits and associated supplies
Continue partnership with Oral Health America for fluoride varnish application kits

c. Plan for the Coming Year
Train nurses to apply fluoride varnish
Home Visiting Program staff to conduct fluoride application at homes
MCH staff to assist with fluoride varnish application
Implement well baby oral health referral and follow-up service
Implement fluoride varnish application service at FQHC - Kagman Community Health Center

E. Health Status Indicators

/2013/One of the things requested by stakeholders during the process of conducting the needs assessment was health status indicators. It provides them with information on infants, children, adolescents, women, pregnant women, etc. From here they will normally request for additional information such as risk factors for some of the indicators. We also use the data to guide us in our program planning especially with limited resources. Because we get information form other programs this allow us the opportunity to review our work and provide the guidance to determine other focus for each indicator with our partners including activities carried out for the national performance measures. We have also learned that in reviewing the indicators with our partners it helps us look at the cultural competency component in our work with the target group. We continue to use demographic data from the 2005 HIES. We look forward to the release of the 2010 Census data as we know that our MCH target group has decreased. For example, due to the closing of the garment industry the demographics for Asian females aged 20-24 years will decrease.//2013//

F. Other Program Activities

//2012// HPV School Campaign: Worked with various partners to conduct an HPV campaign targeted to vaccinate girls in grades 7th to 12th in both public and private schools. A total of 618 girls for vaccinated in a 6 month period.
-HPV and Cervical Cancer Focus Group: An HPV and Cervical Cancer Screening Focus Group which consists of men and women whom have daughters ages 9 to 18 who are eligible for the HPV vaccine or women who are eligible to receive a pap smear was conducted in the CNMI. The focus group discussion is aimed to determine current baseline information on the status of cervical cancer prevention and control in the CNMI, as well as determine knowledge and support by key stakeholders, providers and women. The provider survey will also gather information to inform current human resources for health (HRH) planning and health services planning efforts.
-Second Annual CNMI-wide Diabetes Community Health Forum: Purpose was to 1) enlist community feedback and engage a diverse and representative sampling of our community from key villages; 2) drive community conversations toward evaluating current trends of health services and programs; 3) recommend responsive and culturally appropriate, effective strategies to meet needs; and 4) provide guidance regarding meaningful health policies for our leaders and health practitioners to implement.
-Kick Butts Day: The event is targeted to empower youth to speak up and take action against tobacco use. There were over 500 youths who participated in a rally and dance kick-off.
-Emergency Preparedness: All MCH staff have completed the on-line Incident Command System course from FEMA. Participated in Exercise Konfitma which is an exercise training to test operational response procedures during an incident of national significance and to reinforce interoperability among the state and local stakeholders. Continue to be a partner in Marianas March Against Cancer, Domestic Violence Awareness Month, Criminal Justice Planning Agency Youth Committee, Flu Campaign, and Health and Safety Training for Childcare Providers, etc.//2012//

/2013/We again reiterate the importance of our collaboration with our partners both internal and external especially with outreach activities, awareness events, and public input. Since majority of our partners are under the CNMI Government we all are affected with the reduction of work hours. In the following activities MCH Program was either the lead or assist with facilitation and coordination of the event.

- ***Women's Health Week -- We had a Women's Health Screening Schedule printed in a magnet form and distributed it to all clinics providing services to women. In addition, we also distributed a schedule of prenatal care visits and what happens at each visit.***
- ***Children's Mental Health Day -- partnered with day care centers and read to the children about feelings/emotions.***
- ***Week of the Young Child Event - This year's theme is "Let's Move CNMI for Healthy and Happy Kids". Activities focused on the needs of young children and their families that***

include literacy, nutrition, physical activity, etc.

- ***National Comprehensive Cancer Control Program (NCCCP) and the National Breast and Cervical Cancer Early Detection Program (NBCCEDP): MCH Program Coordinator participated in writing the action plan for Year 1. The applications were approved.***
- ***Autism in the CNM Report -- provided input in early identification, where to go for information, and training sections of the report.***
- ***Head Start Community Assessment -- provided data for the report***
- ***NCD Community Pocket Meeting -- Meetings held at different homes throughout the villages in which we engage the community to respond to the burden of NCDs on our people and to get input from the community on the support needed in order to make successful steps forward.***
- ***Project Brabu -- MCH Program Coordinator appointed to the Advisory Council for the Project.***
- ***Mental Health Awareness Month -- we participated in activities out in the community where we passed the screening magnets and spoke to both women and male about the importance of early screening.***

MCH also continues to participate in the following events:

- ***Cervical Cancer Awareness Month***
- ***Breast Cancer Awareness Month***
- ***Prostate Cancer Awareness Week***
- ***Flu and HPV Campaigns***
- ***Celebrity Bagging***
- ***Domestic Violence Walk***
- ***Board Member of the Commonwealth Cancer Association***
- ***Marianas March Against Cancer***
- ***Criminal Justice Planning Agency Youth Committee***
- ***Triannual Airport Exercise***
- ***Exercise Konfitma***
- ***Kick Butts Day//2013//***

G. Technical Assistance

//2012//TA is being requested to improve knowledge and skills for systems building designed to promote and support and enhance the ability of various partners to work together effectively and efficiently. Other TA requests include support to develop logic models and improve use and interpretation of data. We would also want to request for TA for life course theory so that all DPH program staff will have knowledge to work with MCH Program in incorporating work plan activities.//2012//

/2013/The transition of the Department of Public Health to the Commonwealth Healthcare Corporation has put the Division of Public Health as the lead to search for new funding opportunities to provide assistance in the provision of comprehensive primary and preventive health care services to our community. We have requested technical assistance to establish a grants management office within the Division to ensure that funding opportunities that the CNMI is qualify to apply are reviewed and applications are submitted once FOAs are identified. As was requested and discussed with Region IX consultant, the CNMI would like technical assistance in the implementation of the life course model into mch services to be included in performance improvement activities. In addition, the program wants to integrate chronic disease prevention into maternal and child health services using the life course model. The establishment of the NCD Bureau has moved our efforts to review public health efforts with health outcomes of our community. We are seeking technical assistance for training and implementation of medical home. For the first time the pediatric unit is fully staffed with providers. The MCH Program has provided information -- written and DVD -- to providers but these efforts are not specific to the comprehensive practice of medical home especially for children and

youth with special needs. Additionally, there is a need to develop capacity for healthcare transition to adult providers so that these youths would be better served in their health care needs. The MCH Program sees a need to provide consultation and training around Medical Home for physicians, including those at the private clinics, who provide primary care to our children and youths.//2013//

V. Budget Narrative

Budget and expenditure data from Forms 3, 4, and 5 are provided for the application year, interim year, and reporting year to assist the reviewer in analysis of the budget and expenditure narrative. For complete financial data, refer to all the financial data reported on Forms 2-5, especially when reviewing the federal allocation on Form 2 for the 30%/30%/10% breakdown for the budgets planned for primary and preventive care for children, children with special health care needs, and administrative costs.

Form 3, State MCH Funding Profile

	FY 2011		FY 2012		FY 2013	
	Budgeted	**Expended**	**Budgeted**	**Expended**	**Budgeted**	**Expended**
1. Federal Allocation *(Line1, Form 2)*	470757	376606	469747		469747	
2. Unobligated Balance *(Line2, Form 2)*	0	0	0		0	
3. State Funds *(Line3, Form 2)*	395500	395500	395500		425761	
4. Local MCH Funds *(Line4, Form 2)*	0	0	0		0	
5. Other Funds *(Line5, Form 2)*	0	0	0		0	
6. Program Income *(Line6, Form 2)*	0	0	0		0	
7. Subtotal	866257	772106	865247		895508	
8. Other Federal Funds *(Line10, Form 2)*	518644	518644	286476		292243	
9. Total *(Line11, Form 2)*	1384901	1290750	1151723		1187751	

Form 4, Budget Details By Types of Individuals Served (I) and Sources of Other Federal Funds

	FY 2011		FY 2012		FY 2013	
I. Federal-State MCH Block Grant Partnership	**Budgeted**	**Expended**	**Budgeted**	**Expended**	**Budgeted**	**Expended**
a. Pregnant Women	21657	21657	23823		26865	
b. Infants < 1 year old	21656	21656	23823		26865	
c. Children 1 to 22 years old	285865	242986	282701		286563	
d. Children with	294527	250348	295651		295518	

Special Healthcare Needs						
e. Others	164589	164589	160590		179102	
f. Administration	77963	70870	78659		80595	
g. SUBTOTAL	866257	772106	865247		895508	
II. Other Federal Funds (under the control of the person responsible for administration of the Title V program).						
a. SPRANS	0		0		0	
b. SSDI	94644		9371		14197	
c. CISS	0		0		0	
d. Abstinence Education	0		0		0	
e. Healthy Start	0		0		0	
f. EMSC	0		0		0	
g. WIC	0		0		0	
h. AIDS	0		0		0	
i. CDC	0		0		0	
j. Education	0		0		0	
k. Home Visiting	0		0		200000	
k. Other						
ECCS	0		0		22500	
EHDI/UNHS	0		87505		55546	
ECCS/Home Visiting	0		189600		0	
CDC-EHDI	142000		0		0	
HRSA-UNHS/ECCS	282000		0		0	

Form 5, State Title V Program Budget and Expenditures by Types of Services (II)

	FY 2011		**FY 2012**		**FY 2013**	
	Budgeted	**Expended**	**Budgeted**	**Expended**	**Budgeted**	**Expended**
I. Direct Health Care Services	649693	555542	648935		671631	
II. Enabling Services	51976	51976	51915		53730	
III. Population-Based Services	112613	112613	112482		116416	
IV. Infrastructure Building Services	51975	51975	51915		53731	
V. Federal-State Title V Block Grant Partnership Total	866257	772106	865247		895508	

A. Expenditures

FY2009 Final Fund Status Report reported as total budget of $468,556 and total expenditure of $381,832 or 81%.

Component A, Services for Pregnant Women and Infants, was budgeted at $_25,890_ (6%) of the total federal award.

Component B, Services for Children and adolescent Health, was budgeted at $ _153,480_ (32%) (at least 30% of the total federal award to be utilized in compliance with the 30%-30% requirements).

Component C, Services for Children with Special Health Care Needs, was budged at $_158,765_ (33%) (at least 30% of the total federal award to be utilized in compliance with the 30%-30% requirements).
Administrative costs was budgeted at $_42,406_, which is 10% of the total direct costs of the federal grant awarded. According to OBRA 1989, not more than 10% of the total MCH Block Grant may be used for administering the funds. CNMI applied the 10% as Indirect Cost or Administrative Costs managed by the central government Department of Finance and Accounting. The Department of Finance and Accounting ensures that funds are expended accordingly and processes the Federal Financial Report (FFR) for all federal programs funded to the Division of Public Health.
Personnel and fringe costs were expended as proposed on the budget breakdown and the most of the MCH staff were ongoing FTEs with the exception of the two vacated positions -- Nutritionist and MCH Data Analyst -- which were hard-to-fill positions.
Supplies expenditures supported the costs of routine office -- supplies utilized in the administration office of the Division of Public Health, operational - outreach and public awareness supplies, clinical -- gloves, gauze, alcohol, and other supplies utilized in the clinics, and equipment supplies-- dopplers, one laptop computer, two desktop computers and a printer utilized by the MCH staffs.
Travel expenditures for DPH/MCH staffs -- Out-of-State Travel: MCH Epidemiology Conference, AMCHP Conference, APNLC Presentation, and MCH Block Review; Intra-State Travel: Wise Women Village Project meeting, Hinemlo-ta Training, Headstart Parent's Symposium, and Early Intervention meeting.
"Other" expenditures -- printing of pamphlets, brochures, flyers, and booklets; advertising of the Newborn Screening, Developmental Screening, and other MCH projects; dues paid to AMCHP and NAPHSIS for memberships.

FY2010 Federal Financial Report (FFR) will not be final until 12/31/10

//2012//Expenditures FY2012

The Commonwealth of the Northern Mariana Islands (CNMI) started its austerity measures by cutting 20% of employees' salaries (less 16 hours) since the start of FY2011 regardless of funding source. The implementation of this directive will most likely continue throughout FY2012. This will impact the program by the cutting of working hours and by the tremendous reduction in state funds. The MCH programs and its collaborators were making the best of their funding by sharing resources and manpower to make up for lost working hours and state funds.
The expenditure amount of $1,505,364 out of the FY2010 (MCH & State) budgeted amount of $1,635,026 was shown on Form 3. Expending State funds was challenging due to the drastic decline in revenue collection and the economy.//2012//

/2013/Form 3
CNMI obligated 80% of the total Federal Allocation Funds and the reasons for unobligated of 20% were, under the Services for Children and Adolescent we proposed to recruit a Nutritionist and under the Services for Children with Special Health Care Needs we proposed to recruit an MCH Data Analyst. We were unsuccessful in the recruitments, however, we were utilizing our state healthcare's Nutritionist and Data Analyst. Overall expenditures from all funds total to $1,290,750 or 93%.

Form 4
FY2011 overall (Federal-State MCH Partnership funding sources) expenditures percentage by the type of individual served: Pregnant Women 100%; Infants < 1 year old 100%; Children 1 to 22 years old 85%; Children with Special Healthcare Needs 85%; Others 100%; Indirect Cost 85%. It left an unspent amount of $98,939 (as indicated on Form 3 -- non-recruitment of two FTEs. All Other Federal Funds at 100% expenditure. Overall expenditure (inclusive of all funding sources) totaling to $1,290,750 or 93%.

Form 5
FY2011 expenditures by types of services: Direct Health Care Services 85% (non-recruitment of two FTEs); Enabling Services 100%; Population-Based Services 100%; and Infrastructure Building Services 100%.//2013//

B. Budget

FY2011 budget proposal of $470,757, consisted of:
Component A: $25,890; Component B: $153,480 (33% of the total federal budget); Component C: $160,510 (34% of the total federal budget); Administrative (Indirect) Cost: $42,796 (10% of the total direct costs); and the remaining amount allocated to Supplies: $24,202; Travel: $35,268; and Other: $28,611.
The State MCH match budgeted at $395,500 is comprised of State General Fund dollars which will comply with the required FY1989 Maintenance of Effort amount. The requirement of the 3-4 match of three (3) state dollars for every four (4) federal dollars or 75% of the federal total budget.
The Federal-State Title V Block Grant Partnership is $866,257. Out of the total, $649,693 or 75% was distributed to Direct Health Care Services; $51,976 or 6% to Enabling Services; $112,613 or 13% to Population-Based Services; and $51,975 or 6% to Infrastructure Building Services.
The other Federal funds under the control of the MCH Coordinator responsible for the administration of the Title V program) are SSDI $94.644. CDC-EHDI $142,000, HRSA-ECCS $132,000 and HRSA-UNHS $150,000 and to $518,644. The overall State MCH budget total is $1,384,901.

//2012// Budget FY2012

The CNMI FY2012 Federal-State Title V Block Grant Partnership budget was proposed at grant total of $865,247. $469,747 was proposed on the Federal allocation and that consisted of 32.67% for preventive and primary care for children, 34.17% for children with special health care needs and their families, 5.51% infants, mothers, and pregnant women, 9.09% for administrative or indirect cost, and 18.56% for "Others". The State MCH match budgeted at $395,500 is comprised of State General Fund dollars which will comply with the required FY1989 Maintenance of Effort amount.
75% of the funding was distributed to Direct Health Care Services, 6% to Enabling Services, 13% to Population-Based Services and 6% to Infrastructure Building Services.
Effective October 01, 2011, the Department of Public Health will be transitioning in a public corporation for healthcare and related public health services known as the Commonwealth Healthcare Corporation. As stated on the Public Law, the corporation is intended to be a professionally managed, nationally accredited, independent public healthcare institution that is financially self-sufficient and independent of the Commonwealth Government as is possible. The establishment of the corporation will be a changing environment for public healthcare financing. The MCH program envision the transition to be a success since it will provide more flexibility and authority.//2012//

/2013/CNMI's FY2013 budget proposal totals to $1,187,750 and details as follow:
1. Federal Allocation: $469,747 - earmarked for 32% for Preventive and primary care for children; 33% for Children with special health care needs; and 9% for administrative costs. It meets the 30-30 minimum requirement and administrative costs by not exceeding the 10% requirement.
2. State MCH Funds: $425,761 - The required 3:4 Title V match funds from the state will be from the Healthcare Corporation's general funds including patient fees and other State appropriated funds. CNMI's Memorandum of Effort is $395,500 as required by the state MCH health programs at least equal to the level provided by the state in FY1989, CNMI exceeded the MOE required amount.
3. Other Federal Funds: $292,242 -- consisted 15% from SSDI, Early Childhood Comprehensive Systems, Early Hearing Detection Intervention, Universal Newborn

Hearing Screening and 20% Home Visiting.
The distribution for the Title V Type of Services, CNMI allocated 75% to the Direct Health Care Services (Basic Health Services and Health Services for CSHCN); 6% to Enabling Services (transportation, outreach, health education, family support services, case management, and coordination with Medicaid, WIC, and education; 13% to Population-Based Services (newborn screening, immunization, oral health nutrition, outreach, and public education); and 6% to Infrastructure Building Services (Evaluation, planning, policy development, coordination, quality assurance, monitoring, training, and information systems).//2013//

An attachment is included in this section. VB - Budget

VI. Reporting Forms-General Information
Please refer to Forms 2-21, completed by the state as part of its online application.

VII. Performance and Outcome Measure Detail Sheets
For the National Performance Measures, detail sheets are provided as a part of the Guidance. States create one detail sheet for each state performance measure; to view these detail sheets please refer to Form 16 in the Forms section of the online application.

VIII. Glossary
A standard glossary is provided as a part of the Guidance; if the state has also provided a state-specific glossary, it will appear as an attachment to this section.

IX. Technical Note
Please refer to Section IX of the Guidance.

X. Appendices and State Supporting documents
A. Needs Assessment
Please refer to Section II attachments, if provided.

B. All Reporting Forms
Please refer to Forms 2-21 completed as part of the online application.

C. Organizational Charts and All Other State Supporting Documents
Please refer to Section III, C "Organizational Structure".

D. Annual Report Data
This requirement is fulfilled by the completion of the online narrative and forms; please refer to those sections.